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COMMUNICATIONS.

THE MORBID ANATOMY OF PERI-CÆCAL INFLAMMATION.*

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Much confusion appears to exist in regard to the nomenclature of the inflammatory affections of the region we are about to consider. It may, therefore, be well to state the meaning of the various terms which will be used in this discussion. By typhlitis we shall understand inflammation of the cæcum; by peri-typhlitis, inflammation of the peritoneum covering the cæcum; by para-typhlitis, inflammation of the connective tissue behind the cæcum. The term typhlitis is often used to include inflammation both of the cæcum and of the appendix. We shall, as suggested by Dr. Fitz, use the term appendicitis for inflammation of the appendix, appendicular peritonitis for inflammation of the appendix and its serous covering, and para-typhlitis for inflammation of the connective tissue around the appendix, or, if you please, peri-cæcal.

It is well to know the relative importance of the inflammatory affections in this portion of the intestinal tract. Typhlitis has been considered by systematic writers to be a frequent affection, and yet it is difficult for pathologists to find records of post-mortems in which this condition has been found. It is true that some writers, especially the Germans, have described cases, particularly of stercoral typhlitis, in which inflammation and ulceration of the mucous membrane of the cæcum, by pressure from fecal impaction, was present. Most of us will, however, agree with Fagge that typhlitis is a good general expression, used for all varieties of inflammation occurring in the right iliac fossa; but that, in the majority of cases, the correct term should be appendicitis. Fagge relates a case in which the patient had all the symptoms of peri-typhlitis, with a tumor in the right iliac fossa. He was recovering from this when an acute affection of the pleura caused his death, and at the post-mortem there was found appendicitis, with ulceration and perforation, and not typhlitis. Dr. Wilkes agrees with Fagge in this view, and they consider that the difference in degree of the inflammation alone accounts for the difference in the symptoms, and that most of the cases are due primarily to inflammation of the appendix. That inflammation may occur in the cæcum, as it may occur in any other portion of the large intestine, no one will deny. But we can say, from the records of Dr. Fitz, that perforation of the cæcum is most rare; for, in a most extensive research, he was able to find but three cases, and these were due to foreign bodies. We shall, therefore, with Fagge, consider that appendicitis is the real affection that occurs in the region we are discussing.

A word with reference to the anatomy. The cæcum normally varies much in position as well as in shape. Treves, in his lectures on the anatomy of the intestinal canal, states that the cæcum is most frequently found, not in the right iliac fossa, but on the

* Address at the meeting of the Philadelphia County Medical Society, Dec. 14, 1887.

psoas muscle itself, or in the pelvis; that the cæcum is entirely surrounded by peritoneum rather than only partially; and, therefore, that behind it there is no areolar tissue such as was described by the older anatomists. He does not believe, moreover, that there is a meso-cæcum.

It is also of importance to note variations in the position of the appendix in the consideration of peri-cæcal inflammation. The usual position, as found by Mr. Treves and by Dr. Fitz, is behind the ileum and its mesentery, with the tip pointing toward the spleen. The second most usual position is behind the cæcum with the tip pointing upward. Long appendices usually take this upward direction. Fitz also refers to its lying on the psoas muscle with or without the tip in the pelvic cavity. There are other variations in position. It may stretch across the pelvis and become adherent to the sigmoid flexure of the colon; and in one instance I have seen the appendix in the inguinal canal, associated with hernia. In another instance it was adherent to a pyosalpinx. The appendix varies in size, in the character of its walls, and in regard to its contents. It may vary in length from one and one-fourth to nine inches. There is a famous specimen in which the appendix was nine inches in length, and lay behind the colon, reaching to the under surface of the liver.

In cases dying from causes not associated with this region, the appendix is often found as a cord-like body, having been the seat of previous inflammation. It may have a dilatation either at its blind extremity or in some portion of its length, especially pouch-like at the mouth. Sometimes the entire canal is dilated and filled with catarrhal products. The character of the contents is of importance. Various articles have been found in the appendix, but chiefly fecal masses. Seeds of various kinds, buttons, bristles, worms, shot, pins and gall-stones have also been found. It is in all probability on account of the presence of these foreign bodies that we have the serious secondary symptoms that arise.

I shall next speak of the morbid anatomy of peri-cæcal inflammation. First, with regard to the manner of making an autopsy in such a case. There is usually an extreme degree of peritonitis, and unless the autopsy is made with great care, it will be impossible to find the seat of the perforation, if one exist, and the exact conditions and relations of the peri-cæcal inflammation. The easiest method is to begin at the first loop of intestine that is reached and from that unravel the intestines, separating with great care the adherent parts. If a source of obstruction is found, tie the bowel on both sides and examine the portion in situ, turning the gut if necessary. Such an examination is absolutely necessary in order to make a thorough study of the part.

Inflammation of the appendix is of a simple catarrhal, or of an ulcerative type. That we have catarrhal inflammation we know from the lessons of morbid anatomy. Clinically, however, it would be impossible to determine the presence of such an inflammation. Catarrhal inflammation with succeeding ulceration, local peritonitis, and, finally, perforation, also occurs. In such cases, the following conditions are generally found after death. On section of the abdominal walls there is found, especially in the right iliac region, an œdematous state of the tissues; not only may there be serous œdema, but there may also be infiltration of pus, due to the burrowing from the primary abscess. The peritoneum, if involved, will exhibit an intense degree of inflammation with the characteristic injection, sometimes general, sometimes limited, and more particularly to the right iliac fossa and the pelvis. Serum will be found in the peritoneal cavity, and in some instances pus; blood is occasionally found. In the more severe forms, especially, large flakes of lymph cover the intestines, the parietal peritoneum, and the abdominal organs. The intestines are also more or less adherent to each other, depending upon the duration and the degree of the inflammation. The location of the abscess, for suppuration is usually circumscribed, depends upon the position of the cæcum. There are three positions in which it is most frequently found—either in the right iliac fossa just above Poupart's ligament, or behind the cæcum, or in the pelvis. In a case which recently came under my observation, the abscess was found in the pelvis, one and one-half inches below the level of the psoas muscle, four inches from the anterior superior spine of the ilium on the right side, and two inches from Poupart's ligament. In another case the abscess was found behind the cæcum in the connective tissue of the right iliac fossa. The size of the abscess varies, sometimes containing only two or three ounces of pus, and in other instances as much as a pint or more has been removed. The walls of the abscess differ according to its position. In the first instance mentioned, the upper wall was made up of the cæcum, the right of the pelvic wall, while posteriorly and on the left it was circumscribed by the

adherent intestine. The walls of the abscess may be made up by the intestines alone. The appendix is always found in the abscess, and has undergone changes varying in degree with the duration and severity of the inflammation. Inflammation and ulceration of the mucous membrane, serous or purulent infiltration of the walls, with perforative ulceration and encysted or localized peritonitis, are discovered. In some instances a portion has sloughed entirely off and cannot be found, having undergone dissolution; in others it is found as a soft mass of necrosed tissue. The perforation varies in size; sometimes it completely surrounds the appendix, or even severs it in two; or it is only large enough to admit a probe, while in other instances it can scarcely be detected. Sometimes two or more perforations are found, and frequently they are covered by recent lymph.* The canal of the appendix is very often dilated. We usually find in the canal, near the cæcum, a foreign body; it may, however, be found in the abscess. In the cases detailed by Dr. Fitz, foreign bodies were found in sixty per cent. In other cases their presence or absence could not be positively determined, from haste at the autopsy, from their disintegration, or from their discharge into the bowel, so that the proportion is probably larger than stated. There is one point of importance in reference to the surgery of this region, and that is, that the perforation usually occurs within one and one-half or two inches of the colon. Whatever may be the length of the appendix, the perforation is as a rule found at the point just ndicated.

There are, of course, many cases which do not terminate fatally. Under such circumstances resolution takes place, or the abscess becomes encysted, or the abscess ruptures into some neighboring organ. Dr. Bernardy related a case to me in which rupture occurred in the upper portion of the rectum and also through the abdominal wall at the umbilicus. Dr. Edwards had a case in which fully one and one-half inches of the appendix had sloughed off; the abscess ruptured into the bowel, carrying with it the portion of the appendix and a mass of grape seeds, which were discharged together. The abscess may discharge through the abdominal wall, through the scrotum, into the hip-joint, through the loin or the perineum, or in other directions. Sometimes the pus burrows upward, even as high as and into the pleural cavity. I may say that the bladder is a favorite seat for the rupture of such abscesses.

That cure may take place in cases of perforation of the vermiform appendix, one of my specimens distinctly shows. It was prepared by Dr. William Pepper, and belongs to the museum of the Pennsylvania Hospital. The patient died of another affection. The appendix was cord-like, except in one place, where an old perforation was seen, with organized blood-clot and lymph on the surface.

These are the chief points in regard to the morbid anatomy of peri-cæcal inflammation. In the first place, that peri-cæcal inflammation is due to the inflammation, ulceration, and rupture of the appendix vermiformis, with the secondary formation of an abscess; that the position of the abscess depends entirely upon the position of the appendix; that the further course of the abscess cannot be determined; that in the larger number of cases the inflammation and ulceration are due to the presence of a foreign body occluding the canal—a retention inflammation. The sequence of events appears to be as stated; and while it may appear to be a refinement of terms to differentiate between typhlitis and appendicitis, it is almost necessary in order that a correct and well-defined appreciation of the pathology be determined, so that early and proper treatment may be instituted. Unless such a refinement be made, cases of this kind will be frequently treated as simple typhlitis, whereas in ninety per cent., or perhaps a larger proportion, they are cases of inflammation of the appendix.

DIAGNOSIS OF PERI-CÆCAL INFLAMMATION.*

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I fear that the remarks I shall make may seem vague and desultory, for it is difficult to compress what is to be said within the very reasonable limit assigned. I am quite willing to accept the terms suggested by Dr. Musser, but I do not think that the term para-typhlitis, as indicating inflammation of the peri-cæcal connective tissue, is likely to gain general usage. It is probable that the term peri-typhlitis will continue to be used to indicate inflammation of the walls of the cæcum and of the neighboring connective tissue. Still, anatomically and for parity of nomenclature, it may be well to recognize para-typhlitis as indicating inflammation of the peri-cæcal connective tissue.

The anatomical points made clear by Dr.

*Address at the meeting of the Philadelphia County Medical Society, Dec. 14, 1887.

Musser are very striking. I would merely add to these one or two facts. In the first place, the appendix presents evidences of disease in a very large number of indifferent autopsies. I remember the report of a series of three hundred autopsies, in which there were signs of disease of the appendix in thirty-three per cent., although in none of these was there a history of typhlitis. We have this little organ, singularly useless physiologically so far as we know, placed in a singularly unfavorable position anatomically, very liable to become impacted, so formed that escape of its contents is very difficult, and very prone to become diseased. We must recognize the fact that the appendix is often diseased when we have no reason to suspect such a condition. I cannot agree, however, that the cæcum also is not often the seat of disease. In a long experience, in which I have paid much attention to these cases, I have collected a number of instances of independent cæcal disease, where the cæcum alone presented lesions, sometimes going on to chronic inflammation, ulceration and perforation. The real condition of things seems to be this: In the first place, there are many cases of mild appendicitis which cannot be recognized during life; in the second place, there are a considerable number of cases of typhlitis where the symptoms are chiefly due to inflammation of the walls of the cæcum and of the peri-cæcal connective tissue, which end in recovery. It is impossible in these cases to determine what proportion has been due to appendicitis. Finally, there are also a good many cases of severe appendicitis resulting in ulceration and perforation, with the formation of circumscribed abscess or of general peritonitis. If we could accept the view that perforation of the appendix, leading to peri-typhlitis or para-typhlitis often resulted in recovery by resolution, it would be a matter of comparative indifference where the lesion was chiefly situated; but do clinical experience and anatomical records justify the view that perforation of the appendix, followed by peri and para-typhlitis, often ends in resolution? It is true, that I have found one specimen, and that others have been placed on record where perforation of the appendix has not been followed by grave results, but do these amount to anything comparable with the great mass of cases where lesions of the appendix have occurred with peritonitis and fatal result unless relieved by operation. It seems to me that we have to recognize that while in typhlitis, peri-typhlitis and para-typhlitis, in all probability appendicitis always exists, yet it is often present in only a very mild degree, and can cause only a small portion of the symptoms. This conception seems necessary to a correct diagnosis of these lesions; it is necessary in guiding our treatment.

There appear, then, to be two classes of cases. In one the affection is more limited to the walls of the cæcum and the peri-cæcal connective tissue, and the appendix is affected to a comparatively slight degree. We have no record as to the frequency of such cases. The record is not to be sought on the post-mortem table, for the large proportion of these cases if properly treated from the beginning end in resolution. I have the records of scores of such cases, the vast majority of which ended in resolution. I think the experience of those I address would give a large number of cases of inflammation in the cæcal region so terminating. So large is the number that I cannot consider that in any large proportion of them did perforation of the appendix occur. As I have seen them, these cases are marked by pain as the initial symptom, not excruciating in character, not associated with evidences of collapse, often accompanied with nausea and vomiting, and with elevation of temperature, which continues to rise until decided fever is present. With these symptoms there is excruciating tenderness in the right iliac fossa, a sense of fulness and induration, not rarely with dorsal decubitus and flexed thigh, with a constipated condition of the bowels possibly preceded by one or two irritative movements during the first day, and with these there is considerable acceleration of the pulse. In proportion as the induration and swelling is early and marked, it has seemed to me that the chances are that the appendix is not seriously involved, but that the affection is chiefly one of inflammation of the walls of the cæcum and of the peri-cæcal connective tissue with exudation, and I have no doubt usually accompanied with considerable fecal impaction of the cæcum.

If absolute rest be insisted upon, if abstinence from food, and absolute avoidance of interference with the state of the bowels be adhered to, if local depletion be employed, if counter-irritation followed by the application of the ice-bag, or warm fomentations be employed, and if the internal use of opium and mercury be begun early, the vast majority of such cases terminate in resolution and complete recovery if the convalescent is properly treated—that is, if these restrictions be insisted upon until the sensibility of the part is entirely removed. I am satisfied that the

well-known tendency to the recurrence of typhlitis is largely dependent upon the management of the convalescence from the primary attack. Such would seem to be the diagnostic marks of this type of case.

On the other hand, we know very well that such cases not rarely go on without resolving, that the induration extends, that the symptoms become aggravated and possibly are such as to indicate suppuration, and that at periods varying from seven to fifteen days, pus formation occurs. Such cases demand operative interference, and are successfully treated by the Parker operation. The existence of pus can often be demonstrated by exploratory puncture with a fine aspirator needle.

There is a second class of cases of an entirely opposite character, with which we are all equally familiar. Here the patient may, apparently, have been in almost perfect health, for perforation of the appendix may occur without any previous symptoms of which the patient had complained. But in these cases there has been a catarrhal appendicitis; the fecal matter which is present in nearly every healthy appendix, is no longer able to circulate and escape, because the outlet is partially closed by the swelling of the mucous membrane; the pent-up secretions and the irritating fecal matter excite more serious inflammation in the walls of the appendix; ulceration is established, and finally perforation occurs, and the symptoms of the attack begin. I have rarely seen a fatal case of disease of the appendix where there was not stenosis of its orifice. I think that, to a large extent, it is this tendency to closure, and the accumulation of the secretions and of fecal matter, that causes the more serious type of inflammation and the occurrence of perforative appendicitis.

The first symptom in these cases is usually intense and excruciating pain, so severe at times as to cause collapse, occasionally so severe as to be followed by death in a few hours. Following this there is the rapid development of the signs of peritonitis. The pulse becomes frequent. There is marked tenderness, not in the iliac region only, but also toward the middle of the abdomen. The belly becomes distended, but there is no induration to be felt; there may even be no fulness in the right ileo-cæcal region. The appendix often lies under the cæcum, and I have frequently percussed these cases with great care without finding any evidence of dulness or of induration. After the occurrence of the initial pain, the fever may not rise very rapidly. There may be only moderate febrile reaction for one, two, or three days, associated with continued, moderate pain, simulating an ordinary catarrhal attack with intestinal colic. For two or three days these cases may be viewed as not being seriously ill, so delusive may be the symptoms after the subsidence of the initial pain. In these cases there is absence of ileo-cæcal infiltration, or induration, or tumor, or prominence, or dulness, on percussion. There is in these cases a less degree of vomiting than in the first class of cases mentioned. The vomiting is often rare, and only induced when the stomach is taxed. The bowels are quiet, but not so obstinately constipated and not so strongly resistant to the action of laxatives as in typhlitis, with more or less impaction of the cæcum. After a time, which varies with the intensity of the attack and the direction which the exuded matter has taken, there appear the symptoms of a rapidly spreading, general peritonitis. The belly becomes greatly distended and tender, the coils of intestine are outlined through the tighly stretched skin. The vomiting becomes frequent, the temperature rises, the pulse grows thready and rapid, and we have the familiar signs of general peritonitis. These cases end fatally, from exhaustion, in from five to ten days.

Here are two groups of cases which seem to me to differ not only in degree, but also to differ in the seat of their lesion and the character of that lesion. I cannot believe that in any great number of cases of the first group there is perforation of the appendix. Yet, unless perforation is present, we have seen that all the other lesions of the appendix may exist without the production of any symptoms. Therefore, I cannot attribute to ordinary appendicitis the symptoms of peri-cæcal inflammation which mark the first group of cases. These symptoms we must assign in chief part to the inflammation of the walls of the cæcum and of the peri-cæcal connective tissue.

It is, therefore, of momentous importance that we should be able to diagnose the sort of case that we have to deal with, and that at the earliest moment. I should say, that in proportion as the tumor, prominence, induration, and dulness are marked, delay is safe, especially if rectal examination—the mention of which I have postponed until the last—does not indicate any fulness on the right side of the roof of the pelvis. If this is present, it indicates an amount of exudation which will end in abscess, and is a strong indication for operation. If digital examination, pushed if necessary to the extent of the introduction of the whole hand, reveals no fulness in the roof of the pelvis, I think

delay for several days is justifiable, and with such treatment as I have indicated, the symptoms will, in the majority of cases, subside; and although the case is fraught with great anxiety, resolution will begin, the symptoms will become milder, and the patient recover, and under proper treatment the part will be restored to absolute health without relapse. Even if frequent relapses occur—and I have seen as many as fifteen or eighteen in the same individual—complete recovery may follow a protracted course of treatment with absolute rest, rigidly restricted diet, constant counter-irritation, and suitable alterative treatment internally.

Of course if, after waiting a few days, there is no evidence of the commencement of resolution; if the fever is sustained, particularly if it assume a hectic type, we know from experience that suppuration will not be long postponed. Exploratory puncture should be made, and operation should follow without delay.

The most important question to be considered is: what is the earliest moment that we can establish the diagnosis? On account of the shortness of the time, I limit myself to the differential diagnosis between the two forms of cæcal inflammation to which I have referred. The initial symptoms give us some indication of the seat and the gravity of the attack. Typhlitis and peri-typhlitis soon offer demonstrable symptoms, but as the appendix is hidden under the intestine, the symptoms of perforated appendicitis are often obscure for two or three days. The most careful palpation may fail to show the slightest fulness. The patient may complain of pain over the cæcum, or over the hypogastrium. External examination does not aid us in the diagnosis. Are there any special features which will help us? I would again refer to the importance of the rectal examination. Early and oft-repeated rectal examination is the most important diagnostic means we possess in this class of affections. Often, on opening the body after death, there is no appearance of peritonitis in the exposed coils of intestine. There is no inflammatory process seen outside of the cæcum, and nothing is found until the cæcum is lifted up, when it is discovered that the inflammation is behind it, and extends downward to the pelvis. Sometimes, on removing a layer of lymph, you disclose the pelvis filled with pus. In such cases, if rectal examination should give a sense of distension of the right side of the pelvic roof, might not a puncture be made with a curved exploring needle introduced through the rectum? This has suggested itself to me, although I have never tried it. In this way we might demonstrate the presence of pus, when it would not be possible to do so through the external abdominal wall.

In many of these cases there has seemed to be an unusual abundance of urine and an increased frequency of urination. I think that the former is associated with the absence of vomiting. In typhlitis and peri-typhlitis there is often so much vomiting that very little liquid is absorbed, and the urine becomes concentrated. I have seen cases of perforation of the appendix where the urine was voided at intervals of an hour or an hour and a half, the total amounting to a large quantity. Again, it has seemed to me that in perforation the pain is more apt to extend to the middle line of the abdomen, and sometimes into the genitals, especially into the right testicle and spermatic cord. The agony of pain which marks the initial lesion, the development of fever, the acceleration of the pulse, the distention of the abdomen, the pain referred to some point in the ileo-cæcal region, the comparative rarity of vomiting, the absence of induration and tumor possibly, the ability to detect fulness or induration in the roof of the pelvis by rectal examination, the frequent micturition with a free supply of urine, the pain possibly radiating in the direction of the genitals, have, I think, been, in the majority of cases, the most marked symptoms. Suppuration occurs in these cases very early, even earlier than in the other group of cases. In one case, in which Dr. Keen operated for me as early as the close of the third day, perhaps the earliest operation on record, a pint of pus was found in the pelvis.

So much for the suggestions that I am able to offer with reference to these important affections. The point to which we should bend our exertions should be to determine the early diagnostic symptoms of these two varieties of cæcal inflammation, to see whether there is a constancy in the description that I have given of the first type of inflammation of the walls of the cæcum, which, under proper treatment, offers a considerable hope of recovery. We should, in particular, strive to point out the indications for operation in the two classes of cases. I would ask if general peritonitis may not be a positive indication for instant operation. It has been asserted that general peritonitis is not a contra-indication to laparotomy under other circumstances. If this is the case, the development of general peritonitis in a case of inflammation of the cæcal region would at once indicate operation; for,

after this develops, death results under medical treatment.

I will not take up the question of the diagnosis of these affections from intussusception and internal strangulation. Although this would be necessary for a comprehensive discussion of the subject, the time at our disposal will not permit it on the present occasion.

TREATMENT OF PERI-CÆCAL INFLAMMATION.*

BY THOMAS G. MORTON, M.D.,
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For practical purposes the treatment of peri-cæcal inflammation must be divided into two subdivisions, that of the pre-purulent and that of the post-purulent stage; or, first, before formation of pus or of appendix perforation; and, second, after that event.

The treatment of the pre-purulent, irritative, or simple inflammatory disorders of the cæcum and its surroundings, or appendix, should consist of rest in bed, restriction of diet to nourishing liquids, hot poultices or fomentations frequently replaced upon the parts, perhaps local depletion, and possibly the hypodermatic exhibition of morphia to control pain; whilst the bowels should be kept open and free from accumulation of gas and feces by the administration of salines and enemas—perhaps with the addition of turpentine to the latter.

Those disposed to cavil at the advice just given, I would ask: Shall we keep the bowels in liquid condition, and so best prepared to resist peritonitis, should it occur, whilst at the same time the mere draining of fluid from the intestines and surrounding parts would influence for the better the peri-cæcal inflammation? or shall we paralyze and congest, and inflate the bowels by the old-fashioned "splinting" treatment, and thus becon on peritonitis?

Pain of intense character would often be as much an indication for operative relief as for morphia.

Prompt resolution should take place in cases which are not to go on to the stage of pus formation; and very long continuation of symptoms, or relapses, or recurrences, would be strong indications for surgical interference.

The presence of such tedious recovery, relapse or recurrence would point to the probable presence of conditions exceedingly dangerous to the patient, from liability to general peritonitis or perforation at any time; they further would point, as a rule, to the appendix as the source of irritation and danger. Indeed, in man, that worse than useless appendage must be regarded as the root of most evil in the region under consideration.

To illustrate this point by a single impressive instance, let me quote a case which was reported for me in the Philadelphia *Medical Times* of June 11, 1887. It was that of a woman who, for a long time, had been having mild attacks of abdominal pain, located in the region of the cæcum, which had usually yielded with great promptitude to anodynes. During the course of the last attack of that nature, violent symptoms of perforation and general peritonitis came on. I did not see her until two days after this unfortunate accident; but, though she was then in a most desperate condition, I advised operation as her only chance, and forthwith performed abdominal section. The appendix was found perforated in two places, and violent general purulent peritonitis going on. She died a few hours afterward, but I felt better satisfied that the operation had been performed.

Coming now to our second division, suppose the process to have gone beyond the simple, imflammatory stage, and the presence of pus, even a few drops, to have been diagnosed.

In the great majority of instances, the presence of even a minute amount of pus so near to the peritoneum would be of vastly more risk to the patient than that of abdominal section for its relief. Hence, I should operate whenever the diagnosis of pus had been made—occasionally even without positive diagnosis. But in this paper diagnosis of distinct conditions is presumed, and I am expected simply to outline treatment for those defined conditions; hence, without qualification, I repeat that, pus being present in the region of the cæcum, operation is positively indicated.

Many other risks are to be taken rather than those of purulent peritonitis, for early interference will save most if not nearly all cases from this latter dread complication, while the danger of operation becomes slight compared to that of rampant abdominal inflammation.

Local or general peritonitis supervening in a person who has a history of cæcal trouble, or starting during a first attack, would more than justify operation.

At a later or even perhaps chronic stage of the disorder, all available diagnostic skill

*A paper read at the meeting of the Philadelphia County Medical Society, Dec. 14, 1887.

must be exerted when a peri-cæcal abscess may have pointed in an anomalous situation, and we must ever adhere to the modern surgical rule, always to attack pus at its source, if possible. When the cæcum is normally placed, this is always feasible, if the disease be recognized.

Coming now to speak of actual operative measures, the patient, as a matter of course, must be got into the best possible condition, and surgically clean by the usual methods of attempting these ends. Asepsis should rigidly prevail throughout.

The aspirating needle must never be used, for if it does not find pus we cannot be sure that none is present, whilst its own dangers are not inconsiderable. In these cases it is a poor and especially unsafe diagnostic resource.

The abdominal incision should be lateral, *not* median. For if median, the peritoneal cavity would often be needlessly opened, and the cæcum and appendix cannot well be reached or dealt with through it. But if lateral it can be made of less size, circumscribed abscesses will frequently be found before the peritoneum is reached, and at its base all necessary manipulations can be made upon the cæcum, appendix, and surrounding parts without opening the peritoneal cavity, whilst should the abscess or ulcer have reached that cavity the intestines, etc., can just as well be examined and cleansed through a lateral as a median incision.

Attempts to reach the cæcum by the lateral or subperitoneal incision without opening that membrane, will nearly always be found impossible to carry out, and even should the organ be so reached lesions cannot be properly dealt with at the bottom of such an opening.

The favored or lateral incision should begin at a point an inch above Poupart's ligament and to the outer side of the right linea semilunaris be continued in a vertical direction upward about four inches, and carried down through the parietal muscles until pus, cæcum, or peritoneum encircling that organ be reached. Then the wound can be enlarged, if necessary. If pus be found, wash its containing cavity clean, and get a clear view and careful examination of the cæcum and appendix. The latter is almost always the seat of trouble, and perhaps it would be well to excise it whilst we have the chance in any case, for any cæcal trouble would be likely in time to excite disorder of its appendages. Without a doubt it should be so treated if found inflamed, perforated, or harboring a foreign body. This can best be accomplished by ligating it as close as possible to its cæcal attachment and cutting it off. Cæcal perforations, if found, should be closed by Lembert sutures, whilst ulcers, which may be present, but have not perforated, should by the same means be turned into the bowel lumen. If the general peritoneal cavity has not been involved, the abscess or cæcum or what not in view should be gently curetted, washed out with a one to one thousand bichloride of mercury solution, a large glass or rubber drain introduced, and the abdominal wound closed around it with silk sutures, and a dressing superimposed.

If the peritoneum has become involved and but a short time before the operation, the whole abdominal cavity must be most thoroughly washed out with hot (105° to 110°) distilled water, or one to ten thousand bichloride of mercury solution, and cleansed with sponges, and the foreign body, if that has been the source of trouble, searched for. Should peritonitis be found further advanced, the intestines must be withdrawn, and all adhesions parted with the finger or knife during the process of cleansing and before they are returned to the peritoneal cavity. In the case of general peritonitis a glass drain must be carried to the bottom of the pelvis and kept in working order by means of absorbent cotton ropes acting by capillarity. If a second tube is not used for the superficial or peri-cæcal abscess cavity, the drain going to the pelvis must have perforations as high in it as the level of the cæcum and any surrounding trouble.

If the inflammation should be caused by the presence of a foreign body in the cæcum itself, or by impaction of feces, they must be either excised or urged by prudent force along the bowel. In their operative removal a simple incision, afterward united by Lembert sutures, would answer every purpose.

If portions of the cæcum have sloughed or become gangrenous and the breaches of continuity are too large to approximate with Lembert sutures, without producing dangerous constriction of the gut, we will have to content ourselves with the formation of an artificial anus.

Post-operative treatment would consist in keeping the bowels in a fairly soluble condition, the tube clean, and in meeting threatening peritonitis by active purgation.

These same general principles of treatment will hold even for those rare cases of displacement of the cæcum as into scrotal and other herniæ, its abdominal transposition, etc.; the great question in these cases will be diagnosis.

Typhoid, cæcal, or appendicular inflammation or perforation should likewise receive identical treatment as for the simple inflammatory disorders of that region. This whole subject is still in its infancy, so far as a majority of the profession are concerned, but the child is of almost boundless promise.

I can terminate this going over the field of cæcal inflammatory orders, their pathology, diagnosis, and treatment in no better way than by showing to you the patient whose case was reported to you by Dr. Woodbury, in April last, and upon whom I operated. He has been benefited as much, by the practical application of the principles of treatment which have been laid down, as any human creature ever can be.

DOUBLE OVARIOTOMY; DIVISION OF PEDICLES WITH THERMO-CAUTERY.

BY J. M'F. GASTON, M.D.,

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It may appear to be a work of supererogation at the present day to present the dealings of surgery with ovarian tumors; but some points of special interest in a case recently under my care may be considered as an excuse for giving the following details:

During the month of October, 1887, I was called to examine a white woman, thirty-six years old, who had been married eighteen years, and has had a son fifteen years ago, and a daughter nine years ago, without any subsequent conception. She was of small stature, and thin, not over ninety pounds in weight when in health, and has led an active indoor life until within the past few months. Her menstrual function has not been interrupted, notwithstanding that an abdominal tumor commenced in the right iliac region about three years ago, and has continued to develop until it completely fills the space from the pelvic bones up to the sternum and ribs. Upon instituting an examination, with the assistance of Dr. W. D. Bizzell, first by palpation externally, and then by the vagina and rectum, a multilocular cystic development, with a limited mass of solid matter, was recognized, without any indication of the attachment. An ovarian tumor was diagnosticated, extending throughout the entire anterior portion of the abdominal cavity, with a protrusion corresponding to that of a woman at full term of pregnancy. It descended into the pelvis, so as to press upon the rectum below the promontory of the sacrum, and rested upon the posterior vaginal wall. With the aid of the uterine sound, the womb was found to be crowded out of its proper position, and lay inclined to the right of the pelvis, with normal depth of cavity.

The general health of the patient not being materially impaired, and the growth of the tumor progressing, the conditions indicated a fair prospect of relief by an operation. It was arranged that laparotomy should be undertaken on the 5th of November, and every preparation was completed for the operation, when a lady friend of the patient stated that she expected the tumor to be removed without extirpating the ovaries. This took us all aback, and I proceeded to explain to her that the tumor was formed by the ovary which must necessarily come away with it; while the other ovary might prove to be also diseased, and in this event might have to be taken away. She had evidently been under some misapprehension as to the exact scope of the operation which was proposed, though I had attempted to convey a correct impression of it previously to her and to her husband. I had them both now to understand, in the presence of some of their lady friends, what was to be done, and that their full and free consent for her to submit to whatever should be thought proper by me and my colleagues, after opening the abdomen, was a prerequisite to entering upon any kind of operative procedure. With the proceedings against Dr. Imlack, of Liverpool, before my mind, I determined not to do anything without their explicit sanction to the extirpation of the ovaries, if this was found to be indicated. Having made all clear to them, and receiving their consent to do whatever was thought by us to be necessary for her relief, I applied sulph. morphia gr. $\frac{1}{4}$ and atropin gr. $\frac{1}{150}$ beneath the skin, and the patient was taken by her husband to the operating table, and put under the anæsthetic influence of the A. C. E. mixture by Drs. G. G. Roy and W. B. Parks. In the meantime the hair was shaved off along the linea alba from the umbilicus to the mons veneris, and the surface washed with soap and water, after which the skin was bathed with a solution of the bichloride of mercury. An alcoholic solution of carbolic acid, having twenty-five per cent. strength, with twice the quantity of water, was used for immersing the instruments, and a weaker dilution employed for soaking the sponges after they had been thoroughly cleansed with hot soap and water. With the co-operation of Drs. J. G. Earnest and W. D. Bizzell in the different

steps of the operation, while Drs. Roy and Parks were entrusted with the responsible duty of watching the effects of the anæsthetic, I proceeded with the laparotomy. An incision six inches in length along the median line, below the umbilicus, was carried down to the peritoneum, when a portion of this membrane was seized with a forceps at the lower end of the external incision, and snipped with scissors, so as to admit a director, upon which the division was made with a narrow bistoury. The opaque sac of one of the cysts presenting was secured with a volsellum and punctured with a large trocar having an elastic tube attached to carry off the fluid contents. Upon being completely evacuated the opening was ligated with strong silk thread and dropped, whereupon other cysts were treated in the same manner, until four were emptied, thus reducing the multilocular tumor until it could be readily brought out at the incision. The pedicle was transfixed by a varicocele needle, armed with a double ligature of No. 14 iron-dyed silk, which was cut in the loop and tied firmly about each portion of tissue, when the ends were cut close to the knot. The outer segment of the pedicle was then divided, an inch from the knot, by Paquelin's thermo-cautery and dropped. While Keith and others have used the actual cautery for searing the cut surface of the pedicle, I am not aware of this process of division of the pedicle by the thermo-cautery being used previously. Upon examining the other ovary it was found to have undergone cystic degeneration, and to have an irregular outline corresponding to the size of a hen's egg, which led us to conclude that it should also be removed. The process of ligation and separation was the same as previously executed, and there was no exudation of blood from either stump; yet some sanguineous effusion from the edges of the external incision had found its way into the cavity, while one of the cysts was so small as not to admit of ligation, and might have allowed a slight escape of the residuary fluid into the peritoneal cavity.

Under these circumstances, it was thought best to wash out the abdomen, and a five per cent. solution of the carbolized alcohol in warm water was poured through the incision, until the cavity was entirely filled. After manipulating the walls of the abdomen so as to cause any foreign matter to become dissolved in the water, the patient was turned upon her side, while the hands prevented any escape of the intestines and the water was discharged, excepting a residue which was soaked up by sponges. The edges of the peritoneal lining were now brought together separately by a continuous catgut suture, and the cavity thus effectually closed. A different course has been pursued by other operators; but, when it is considered that the peritoneum is loosely attached by cellular tissue to the parietes, and is more or less movable in its normal relations, it must appear injudicious to fix it in the linear cicatrix by a deep suture. The skin and fascia were united throughout the entire length of the incision by eleven points of interrupted suture, with No. 12 iron-dyed silk. The line of union was dusted over with iodoform, covered by a thick layer of antiseptic gauze, extending over the entire abdominal region, outside of which was placed some folds of the absorbent cotton, and a broad retention bandage was fastened firmly around the body.

The anæsthetic was now withdrawn, after being kept up for an hour without any untoward developments; and the patient's condition gave no apprehension of shock or other evidence of vital depression. My observation of the safety and efficiency of this combination of one part of alcohol, two parts of chloroform and three parts of ether, known as the A.C.E. mixture, has caused me to use it during the past three years in all surgical operations in preference to chloroform or ether separately. It is not, however, free from the subsequent nausea which attends the long-continued inhalation of anæsthetics, and the patient had some retching during the afternoon; but she was relieved by a mixture of lime water, f℥iij; camphor water, f℥ij; peppermint water, f℥j; in tablespoonful doses every hour.

The night after the operation was passed in comparative comfort, though there was considerable thirst, which was allayed by a limited supply of water and small pieces of ice. The urine was drawn off early next morning, and presented nothing abnormal in its characteristics.

Being unable to pass her urine in the recumbent position the catheter was continued night and morning, there being no indication for more frequent evacuation of the bladder during the first few days. Her bowels were moved by an enema of ox-gall with warm water on the fifth day. The febrile reaction ranged from a temperature of 100° to 102° during the first week, while the pulse counted usually from 110 to 115 per minute. Slight nourishment was taken in moderation after the second day, with a limited amount of water to allay thirst. She took at night a triturate of morphia ¼ grain and atropine

$\frac{1}{150}$ grain, to secure composure, as it was not indicated to relieve pain. Upon renewing the dressing on the fourth day, the incision was united by first intention; and on the seventh day six of the stitches were removed alternately. On the tenth day the remaining five were taken out, without the slightest sign of suppuration at any point. The line of union was again dusted over with iodoform, and the layers of antiseptic gauze were applied fresh, with a new compress of cotton over it, all being well secured by a broad bandage around the body.

In the meantime I allowed her husband to use the catheter in drawing off her urine more frequently, this being called for by her desire to urinate in my absence; and some irritation was set up in the bladder, causing a burning sensation each time after its evacuation, with the presence of some purulent deposition. In view of this vesical trouble, it was determined to dispense with the further use of the catheter; and as she could not pass her water while lying in bed, she was lifted upon the stool, from the end of a week after the performance of laparotomy, as often as three or four times a day, for the relief of the urinary accumulation, and returned afterwards to the bed in the recumbent position.

An interesting phase of this case was the appearance of the menstrual flow on the third day after the operation, and a somewhat free discharge continued for four days, when it gradually disappeared. As she had menstruated during the week preceding the laparotomy, this recurrence was out of time and may perhaps be accounted for by the irritation propagated along the ligated tubes. It was no doubt beneficial as a local derivation from the pelvic traumatism, and the absence of any inflammatory development was probably due in part to this sanguineous discharge at a time when the reaction might have caused trouble on the part of the wounded structures within the abdominal cavity.

The intestinal functions being torpid, enemata of ox-gall with warm water were resorted to repeatedly, at the close of the first week, without producing the desired effect, when the calcined magnesia was used; but failing to act on the bowels, cream of tartar was taken two days in succession, with a recurrence to the enema of warm water having soap and table salt dissolved in it, securing thus a proper evacuation after dislodging some scybala from the intestinal canal.

During this perturbation connected with the bladder and bowels, the temperature dropped rather suddenly, and on the eighth day from the operation was two degrees below normal, with acceleration of the pulse, but on the following day had risen to 97½°, and on the subsequent day returned to the normal standard. This was too late to be attributed to shock from the laparotomy, and was evidently not connected with any septic contamination, so I attributed it to the depressing complication of the disorder of the bladder and intestinal canal, and not to the ovariotomy.

About the end of the second week an anomaly was presented in the secretory function of the mammary glands being developed after its cessation for nearly eight years, and milk was drawn from the breasts continuously during the further observation of the case, which corresponded to the ordinary lactation developed after parturition. We have sufficient grounds for stating that the function of lactation is not interrupted in the inferior animals by spaying, but that a secretion, which had been dormant so long, should be revived by the removal of the ovaries in the human female is a most remarkable feature of this case.

The patient, as already stated, was lifted from her bed after the first week to facilitate the discharges from her bladder and bowels. But after the fifteenth day she rose with some assistance and walked to and from the stool, spending a short time each day in an armed chair; and though her pulse ranged usually from 120 to 130 beats to the minute, her temperature continued normal, and there was no complaint of soreness over the line of incision or in any other portion of the abdomen. There was usually given at night a triturate of sulph. morphia ½ gr. with sulph. atropin $\frac{1}{150}$ gr., under the effect of which she slept during most of the night. As the bowels continued torpid, laxatives followed by enemata were employed at intervals of two or three days.

Upon having their purgative effect, great discomfort and depression of her powers ensued, followed by griping pains in the bowels. Whiskey, alternated with camphor and asafœtida, usually gave relief, accompanied with the external application of camphorated spirits of turpentine. Occasionally there was acute pain extending from the left iliac to the pubic region, with recurrences of the burning sensation after urinating and the continued deposition of more or less pus from the urine, which was voided frequently in small quantity. This was attributed to a complication of cystitis with pyelitis, for which sweet spirits of nitre f℥ss and spirits of turpentine gtt. xv., in mucilage of gum arabic, was given four days in succession,

three times a day, with evident advantage.

While the appetite called for a liberal allowance of nutritive food, and digestion usually progressed satisfactorily, there was at times acidity of the contents of the stomach, for which a half teaspoonful of soda served as a corrective.

As a tonic she was given a mixture of compound tincture of gentian f℥iv and tincture of nux vomica f℥ij, in teaspoonful doses three times a day, with marked improvement in all respects; so that at the end of six weeks after the operation all trouble connected with the bladder and intestinal tract had ceased, and there was no vestige of any inflammatory development connected with the laparotomy. Dec. 18, the patient drove out, and spent the day with a friend, and on the following day I found her entirely well.

EPIDIDYMITIS AND ORCHITIS.

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WASHINGTON, D. C.

Epididymitis and orchitis are most commonly presented as complications of gonorrhœa, and rarely show themselves before the beginning of the second month of a gonorrhœal discharge. As long as the gonorrhœal inflammation is confined to the anterior portion of the urethra, epididymitis and orchitis are exceedingly rare as complications of gonorrhœa; but when a gonorrhœa runs into the second month, the inflammation is apt to gradually extend to the deeper part of the urethra, and from thence, through the vas deferens, to the epididymis. This result is produced in about ten per cent. of the cases of gonorrhœa. Sometimes the inflammation confines itself to the epididymis, and extends no farther; but this is of rare occurrence. The rule is, for the inflammation to extend from the epididymis to the tunica vaginalis, and to the body or substance of the testicle itself, thereby causing acute orchitis. The left testicle is more frequently attacked than the right; but, now and then, both testicles will take on inflammation at the same time, producing double orchitis. When the epididymis and testicle are equally involved in inflammation, it is a difficult matter to distinguish them by the touch; and it is only when the inflammation is not severe, and is not accompanied by an effusion into the tunica vaginalis that it can be ascertained by manipulation that the epididymis is alone concerned in the inflammation. The symptoms are of an active and decided character; and, like those of other local inflammations of a pronounced nature, are too indicative to require an enumeration; and a little inquiry in reference to concomitant symptoms soon invites an easy diagnosis.

The Treatment.—The relief which rest gives to the inflamed epididymis and swelled testicle indicates that the recumbent posture must be constantly maintained in the treatment of inflammation of these organs; and the ease which the lifting the weight of the enlarged and swollen testicle off the tender spermatic cord affords, likewise points out the necessity of keeping the bottom of the scrotum on a level with the top of the thighs, while the recumbent position is steadily maintained. This can be easily accomplished by bringing the testicles to a comfortable height by suitable packing between the thighs. A cloth, frequently wetted with the following lotion, should be constantly applied to the scrotum:

℞ Vinegar,
Water.....āā f℥vij
Tinct. of arnica.....f℥iiss
Powd. muriate of ammonia....℥vj
Mix. Sig.—Shake well, and keep constantly applied to the swelled testicle.

Having enjoined the recumbent position, and placed the testicle in the right position, the next duty is to adopt such internal or constitutional treatment as will be most likely to relieve the epididymis and testicle of their abnormal condition. My plan of treatment has been very satisfactory to me, and has always afforded me speedy and prompt success. The stomach will be found sick, the tongue coated, the skin hot, the pulse quick, and the bowels constipated. I usually order 5 grs. of calomel and 10 grs. of blue mass, made into three pills, at one dose; and in three hours after the pills have been taken, I have administered a half ounce of sulphate of magnesia, and this dose of salts I direct to be taken once a day afterwards, in order to keep the bowels in a soluble condition. It is a well-known therapeutical fact that iodine and its preparations exert a positive effect upon the glandular organs of the body; and in order to avail myself of this physiological action of the iodine preparations, I use the following internally:

℞ Iodide of potassium,
Bromide of potassium.....āā ℥j
Fl'd ext. of aconite root.....gtt. iij
Camphor water..... f℥vj
Mix. Sig.—Shake well. Dose, a tablespoonful every hour.

This dose I have continued every hour until the inflammation begins to diminish, and then

the interval is made every two or three hours, and the medicine continued at these intervals until the swelling and induration of the testicle have entirely disappeared. At the end of from two to four days the orchitis is so much relieved that a suspensory bandage can be worn, and a cautious return to locomotion permitted. Under this treatment the gonorrhœa is very much benefitted, and by the addition of two copaiba capsules, three times a day, the discharge from the urethra rapidly disappears. If the iodide of potash mixture and the copaiba capsules are continued for twelve days after the gonorrhœal discharge has ceased, a cure will be very surely made.

FŒTAL MEDICATION.

BY T. CURTIS SMITH, M. D.,
AURORA, INDIANA.

At first presentation of this thought to the mind, it may seem unreasonable to think of giving remedies to the fœtus in utero. If it includes the idea of direct medication, it certainly would at once be looked upon as an impossibility. But, if we consider the question of dosing the growing intra-uterine inhabitant by an indirect and circuitous route, I think we will find it feasible and practical.

Few medical men need be told that the quality of the mother's blood, her tendencies or her diseases, have great influence over the fœtus *in utero;* any dyscrasia of the mother, any severe disease with which she is suffering is likely to appear in her offspring. The influence of the blood of the mother upon the state of the fœtus is not effected by direct communication, but by a process of osmosis going on in the tissue of the placenta. Cases illustrative of this fact are not wanting. One, which is famous in its way, is that of a French woman who nursed a child with variola while she was pregnant with another; and, when the latter was born, it presented well-marked pustules of small-pox. Sir James Y. Simpson has recorded similar instances in his works on obstetrics. He says: "During the last month I had an opportunity of seeing two cases of variola in the fœtus. Both children were born dead.

"*Case I*—The first case occured in the practice of Dr. Purdie. The child was near the full time. The variolous eruption was scattered freely over the whole cutaneous surface, in the form of pustules. Several of the pustules were umbilicated. The mother, at the time of the birth of the child, was laboring under an advanced stage of an attack of modified small-pox.

"*Case II.*—In the second case, occurring in the practice of Dr. Gordon, the fœtus was expelled about the fifth month. The pustules were principally confined to the trunk of the fœtus, and consisted chiefly of flattened collections of matter. The mother was recovering from modified small-pox. Intra-uterine small-pox has now been observed by Mead, Jenner, Hosack, and other pathologists.

The fact that the poison of variola can thus produce the disease in infants yet unborn, clearly demonstrates the close connection between the circulation of the mother and that of the fœtus. In one case referred to above, the mother did not herself have the disease, yet her little uterine tenant was born with well-developed variolous pustules. Again, fairly clear evidences of scarlatina and rubeola being conveyed to the fœtus can be adduced were it needful to do so.

An appreciation of the influence of the maternal blood on the condition of the fœtus can be turned to practical account in preventing certain diseased or disordered conditions. In syphilis, for example, medication of the mother is of the greatest service to the fœtus. An illustration of this may be cited from my own practice:

Mrs. X., twenty-six years old, well built, formerly of a sound constitution, had a syphilitic husband, but was unaware of his condition. She had been married six years and had had three abortions. At the time referred to, she had no evidence of uterine disease; but she had enlargement of the post-cervical glands, chronic throat disease, and a distinct history of eruptions. She was very anxious to have a child. I placed her on "specific" treatment for six months, and treated her husband in a similar way. At the end of this time impregnation was allowed to take place, and treatment of the woman was continued nearly to the end of her pregnancy. At the end of her full term she gave birth to a vigorous and apparently healthy infant, which was under my observation for eight years, during which time it appeared healthy to ordinary observation, although the marks of hereditary disease were discoverable by the skilled eye.

Other children were afterwards born to these parents without special treatment, and though they distinctly bore the marks of contamination, they grew up with average vigor and strength.

Again, it is no uncommon occurrence for obstetricians to be called to cases of labor

where there is a "false alarm." This may occur several times in a single case. Not in all, but in a large proportion of such cases, I have found the fœtus in continuous and somewhat violent motion; and I have been led to believe that its intra-uterine gymnastics were the sole cause of the uterine pains. Whenever it stirred forcibly, there would be false labor pains; and whenever it was quiet, there would be none. In the early years of my practice I was kept needlessly at the bedside for many hours in some of these cases. Later, I learned to quiet the fœtus by a pretty round dose of tincture of opium, or of some of its equivalents. In a half hour, or an hour, after giving such a dose, the fœtus would cease its gyrations, and the pains would also cease. I have repeated this practice very many times in twenty-five years' work.

Our obstetric works, I think, take a wrong view of the cause of the false labor pains in this type of these cases. I know there are some cases of simple uterine irritability, where the pains come in advance of time, and need to be quieted by an anodyne or uterine sedative. And also there are cases of malarial uterine neuralgia where quinine or other like salts are needed to allay the regular diurnal or bidiurnal return of false labor pains. But in the type of cases I have described above, the pains are caused by the violent movements of the fœtus, which irritate the uterine walls and lead to contractions and pains.

If clinical experience is worth anything it proves that remedies administered to the pregnant woman produce their effects upon the fœtus through the medium of the blood, which reaches the fœtus by osmotic action. This action is quite free and effectual, and when narcotics are used the result is prompt —so prompt indeed that we should use these agents with care in pregnant women. I have never seen a female morphine-eater bear a living child while under the habit.

Again, a syphilitic woman who is pregnant will increase the chances of the viability of her offspring by persistently using antisyphilitic agents from early in the term to its close; and any dyscrasia of a pregnant woman, if it be likely to affect the fœtus unfavorably, may be met by proper treatment, with a reasonable hope of benefitting both mother and fœtus.

Violent intra-uterine movements may be readily controlled by anodyne or uterine sedative agents.

The administration of any powerful remedy to the mother may cause the death of the fœtus, so that such medicines as opium should be given with great care.

The fœtus may be affected by and even destroyed by the contagium of disease absorbed into the mother's blood, such as variola or scarlatina, though she herself may not have the disease; while, if she be affected with these diseases, the fœtus is liable to die in consequence of her disease.

Any disease which interferes with the normal supply of oxygen in the blood of the pregnant woman will endanger the life of the fœtus: as in pneumonia, bronchitis, typhoid fever, etc.

Diseases which interfere with the normal development of the placenta, endanger the vitality of the fœtus, because it renders the blood-supply to it insufficient.

Society Reports.

PHILADELPHIA COUNTY MEDICAL SOCIETY.

Stated Meeting, December 14, 1887.

The President, J. Solis-Cohen, M.D., in the Chair.

The meeting was devoted to the subject of

Pericæcal Inflammation.

The discussion on the pathology, diagnosis, and treatment of this disorder was opened by appointment by Dr. J. H. Musser, Dr. William Pepper, and Dr. Thomas G. Morton, whose remarks are published in the preceding pages of this number of the Reporter.

The general discussion was opened by Dr. W. W. Keen, who said: I remember very well the first post-mortem that I made in private practice, twenty-one years ago. It was on a patient who had died of typhlitis without operative treatment, and the question arose in my mind, at that time, whether or not a surgical operation might not have relieved him. This was in the year 1866. In 1867, Willard Parker, of New York, practically systematized the operation. Since then, the sense of the profession in general has been more and more toward the operative treatment of these desperate cases.

I should like to say a word or two with reference to the diagnosis. I have seen many of these cases, and I have yet to see one in which a distinct tumor was present. As a rule, tumefaction will be found, but no tumor. Nor is any fluctuation found in these cases. In a case which I saw in consultation eight years ago, there had been extensive infiltration in the right iliac fossa, for three weeks; but there was absolutely no tumor and no fluctu-

ation; yet, when the cavity was opened, a pint of pus was found. We should make up our minds positively, in reference to the surgical treatment of these cases, that we are not to wait for the formation of a distinct tumor or the presence of distinct fluctuation.

Another symptom, to which Dr. Pepper alluded, I have not found a constant one—and it is surprising that it is not—that is, the flexing of the right thigh. Not only may this be so, but all the other symptoms may be fading, and yet pus be present. In the Medical and Surgical Reporter, February 6, 1886, p. 165, I reported a case in which I operated on the sixth day. The symptoms had followed the ingestion of a large quantity of grapes, the temperature reaching 102.8°. The fever and pain had nearly disappeared, and the other symptoms had ameliorated to such an extent that convalescence seemed almost established. Here the diagnosis and treatment hinged upon one measure, which I was rather surprised to hear Dr. Morton condemn—that is the use of the aspirator. He, however, did not speak of the hypodermic syringe, and I do not know whether or not he includes that in his condemnation. In these, and certain other cases, I think that the use of the syringe for exploratory purposes is strongly to be commended. I grant that it is not always safe to use the smallest of the needles of the aspirator; but to the use of the hypodermic syringe I see no objection whatever. If it penetrates any normal structure, it will do no harm; and if it reaches pus, it gives a positive indication for operation.

The time at which pus forms is often extremely early. I have had two cases in which on the sixth day a large quantity of pus was found. Both of these cases made excellent recoveries. In the case seen with Dr. Pepper, pus was found as early as the close of the third day.

I was glad to hear Dr. Pepper refer so strongly to the importance of the rectal examination in these cases. Others have alluded to this, but the urgent importance of it has never before been seriously dwelt upon. Dr. Musser has shown that the appendix often lies directly on the brim of the pelvis. If the perforation be near the cæcum, the pus will find its easiest outlet, in not a few cases, toward the cavity of the pelvis. It is, therefore, in the majority of cases, within easy reach of the finger; and, in an urgent case, if it cannot be reached by the finger, the introduction of the hand, provided it be a reasonably small one, may be practiced.

Both Dr. Pepper and Dr. Morton have alluded to operation in these cases. As is well known the operation of Dr. Willard Parker consists of an incision not vertical, but parallel, to Poupart's ligament. This incision will do very well in the majority of cases, where the lesion is situated in the right iliac fossa proper. Either this or the vertical incision to which Dr. Morton alluded, may be selected. As we go further and do not find pus, the hypodermic syringe may be used for purposes of further exploration. In the second class of cases alluded to by Dr. Pepper, where there is perforation of the appendix, where there is absence of induration in the right iliac fossa, and especially if there is general peritonitis, I should certainly favor median and not lateral laparotomy. The latter does not give so simple and bloodless an operation; nor does it give us so easy access to the cavity of the pelvis for exploration, for drainage, and for the surgical manipulations that may be necessary. In the case I operated on one year ago, for Dr. Pepper, I regret that I did not do a median operation at once, instead of doing the lateral operation. The median operation will give us every facility for operation on the viscera in the right iliac fossa, and especially will it give us access to the appendix. Unless the indications for lateral operation be strong, I should favor the median incision.

I should hesitate to perform puncture of the rectum. It would be far better to do a laparotomy, rather than be in the dark, not knowing what the lesion was, and simply drain the cavity of the pelvis, as we would do by rectal puncture. We want to know what condition exists; we want to find out the exact facts. Exploratory operation is not only constantly done, but done, I may almost say, without any additional risk to the patient, and it gives us the means of dealing with whatever lesion we may find. If the appendix is perforated, we should ligate it and remove the diseased portion. If the cæcum should prove to be the seat of perforation, we should close the opening with the Lembert suture. If the perforation is too large for this, it will be necessary to follow the plan suggested by Dr. Morton, and make an artificial anus.

Dr. W. Hunt said: The suggestion has been made that treatment with salines should take the place of the opium treatment in these cases, especially after operation. This is a point on which more experience is needed before we can reach a decision. When we take into consideration the fact that several cases of perforation of the appendix have been known to get well under the opium treatment, as proved by post-mortems long

after, and also the fact that the mortality, after the adoption of that treatment years ago, fell to a large extent, we should not hastily abandon it. It is no wonder I feel kindly toward it: for I am told that I am indebted to the opium treatment for my recovery from an analogous lesion,—*i. e.*, perforation of a typhoid fever ulcer.

A word with reference to the operation of ligating and cutting off the appendix. It seems to me that by this method it might possibly be found that only mucous surfaces had been brought into contact and adhesion not secured. It would be better, after removing the diseased portion, to close the stump by the Lembert suture.

Dr. Wm. Osler said: I should like to make one or two remarks bearing upon the anatomy of this region. There can be little or no doubt that the cæcum—namely, that portion of the large intestine below the orifice of the ileum—is, in ninety-five per cent. of all cases, absolutely free. In the one hundred cases analyzed by Treves, there was not one meso-cæcum. If he had examined five or six hundred cases, he might have found two or three. I have the records of many instances in which the cæcum occupied the classical position, and was surrounded by peritoneum only on the front and sides; and last week, in two cases in succession, a well developed meso-cæcum was present.

It is remarkable how large a number of cases of appendix disease recover. I have carefully gone over my notes, and I find six cases of obliteration of the appendix. There had been peri-cæcal inflammation with subsequent obliteration. I find a record of eleven cases of ulceration: seven in phthisis and four in typhoid fever. I have never met with foreign bodies in the appendix; but I have on two occasions had foreign bodies brought to me that had been found in subjects in the dissecting-room.

The important point in connection with perforative appendicitis, is that in the majority of cases the perforation occurs first with slight inflammation in the neighborhood, perhaps lasting a few weeks or months, without exciting any special symptoms; and the first symptoms to which the attention of the physician is called, and which are rapidly followed by peritonitis, are those of perforation, not of the appendix, but of the appendiceal abscess. In five instances of peri-cæcal abscess which I have examined, in every one of them there was evidence that the abscess had lasted some time. That this is the case is evident from the fact that there are many instances—of which I have had three—in which there was no perforation into the peritoneum, and no peritonitis occurred, yet there were signs of septic fever. The perforation had led, not to general peritonitis, but to inflammation of the portal branches and diffuse abscess of the liver. This is a point which, I think, has not been sufficiently recognized in dealing with these cases of perforation of the appendix.

With regard to cæcal disease, we have all seen the cases which have been described by Dr. Pepper. I think that they result, in the majority of instances, from impaction; and that the induration which we feel is in most cases fecal is, I think, evident. As Dr. Pepper has said, it is important to distinguish between these cases and appendicitis, for the majority recover. We, however, learn from post-mortem examinations, that a considerable number of cases of perforation of the appendix also get well—cases, too, in which there have been no special symptoms.

I have had three cases of peri-cæcal abscess from disease of the cæcum. Two were cases of round ulcer of the cæcum. In both the cæcum was the only part involved, the ulcer not being larger than a quarter of a dollar. In both instances the perforation was posterior and had excited suppuration in the tissues as high as the kidney. In one instance the abscess had been opened in the loin and had discharged very freely. In the third case the perforation was due to cancerous ulceration. There was in this case a large perforation just beyond the orifice of the ilium.

Dr. J. C. Wilson said: I should like to indicate a division of the subject which I have not thus far heard mentioned. Dr. Pepper has alluded to the form of inflammation which is so common, and which is probably due to fecal impaction. A large proportion of these cases recover, and the anatomical condition must remain, to a large extent, in doubt. I am disposed to regard it as a local enteritis involving the cæcum, and, perhaps, the appendix. I believe the fulness that is present is due in part to fecal impaction, and in part to plastic exudation around the bowel.

In the second place we have those cases in which there is the formation of peri-cæcal abscess, more or less limited in extent, and in course of time this will require surgical interference.

The third group of cases is that in which there is more or less extensive and general peritonitis; and this peritonitis may be due, as Dr. Osler has pointed out, either to rup-

ture of a peri-cæcal abscess or to primary rupture of the appendix, with the escape of its contents into the peritoneal cavity., I believe that in this form we have to deal with two essentially different processes. In the first place, we have those cases in which we have rapidly developing peritonitis as the result of the escape of the contents of the appendix, or of a peri-cæcal abscess; and these cases demand the surgical interference which has been indicated to-night. I believe that there is another class of these cases in which the peritoneal process results, not in purulent exudation finding its way down into the pelvis, but in plastic exudation from the beginning. Here we have the typical symptoms of general peritonitis without the formation of pus. These cases, I am led to believe from my own experience, not only terminate in recovery, but do better without than with surgical interference.

Dr. J. S. Neff said: The early period at which pus formation takes place in these cases has been referred to. I would only mention a case which illustrates the rapidity with which general peritonitis may appear. I made a post-mortem on a child which was struck with a stone, causing rupture of the bowel. Death occurred seven or eight hours after the accident, not from shock, but from general peritoneal inflammation.

Dr. E. Montgomery said: I have met with a number of cases of these affections. It is certainly difficult to decide what should be our plan of treatment. We have cases in which this trouble exists, and goes on to local peritonitis, and under proper treatment recovery occurs. We have other apparently similar cases which end fatally under the same treatment. Three cases have come under my observation: One was a man some twenty years of age, who complained of severe pain in the right iliac and inguinal region, with considerable tympanites and with symptoms of peritonitis. Leeches, followed by hot poultices, were applied, and morphia administered hypodermically. By the seventh day the acute symptoms began to subside. On the morning of the eighth day he had a severe lancinating pain in the side, with collapse, followed by death a few hours subsequently. The post-mortem revealed gangrene of the end of the appendix. This had been circumscribed by plastic exudation. At the time that the lancinating pain had occurred, an artery had been opened and hemorrhage had occurred, which broke through the exudation, and a pint of blood was found in the peritoneal cavity.

The second case I saw in consultation thirty-six hours before the death of the patient, who was a man fifty years of age. There were marked signs of peritonitis, with great distention of the abdomen, greatly interfering with the breathing. It was not deemed advisable to operate. As there were constant efforts at vomiting, I introduced the stomach tube. This was followed by the regurgitation of half a pint of black material. This gave considerable relief from the distress, and the abdomen was much reduced in size. On post mortem examination, perforation of the appendix was found.

The third case was one of those reported to-night, in which operation was performed.

I have now under treatment a patient seventeen years of age, who, during the last six months, has had eight or ten attacks of tenderness in the right inguinal region. Although he has been in bed for the past three weeks on a restricted diet, he is now suffering from another recurrence of the symptoms. It is a question whether or not in this case it would not be better to do a laparotomy for the purpose of removing the appendix when the inflammation subsides.

Dr. E. T. Bruen said: The treatment of peritoneal inflammation by salines is receiving considerable attention at the present time. From what has been said to-night, it would seem clear that in the treatment of typhlitis the important measures are those which secure rest, including the use of opium and the avoidance of all violence; and when the inflammation has subsided, the removal of the impaction by such mild laxatives as calomel; and, besides this, the treatment of the catarrhal condition by appropriate measures.

In those cases where there has been rupture of the appendix, with the occurrence of peritonitis, it seems improbable that the administration of repeated doses of salines would be likely to do much good. I think that the expression of medical opinion as to the measures to be employed under these circumstances should be clear.

Dr. J. H. Packard said: I would briefly refer to one or two of a number of cases illustrating the subject of this evening's discussion, which have fallen under my observation.

The first occurred in the practice of the late Dr. J. F. Meigs, in 1860, and is reported in detail in the *American Journal of the Medical Sciences* for 1861. At the autopsy, made by me, an intestinal concretion had been lodged in the appendix vermiformis, and had caused a circular band of ulceration, at one point of which perforation had taken place. There was a collection of pus about

the appendix, and universal suppurative peritonis, with flakes of lymph on the coils of intestine.

Another case, which occurred in 1879, in my wards at the Episcopal Hospital, may illustrate the difficulty of diagnosis sometimes met with in these cases before the recent advances in the surgery of this region had been made. A boy, about seventeen years of age, who had worked on a farm, was admitted on account of lameness, ascribed by him to ulceration of his right heel by a heavy and ill-fitting shoe. There was a swelling in the upper part of the thigh, which was regarded as a sympathetic bubo. At the lower part of the abdomen there was also some fulness and tenderness, which should have attracted more attention than it did, and which ought to have suggested the true nature of the case. Several openings occurred below Poupart's ligament; the discharge was very abundant, and soon became fecal in character. A little later, fluctuation was noted above the ligament. Parker's operation was performed, and a small angular piece of beef-bone was found that had worked its way out of the bowel. A more radical procedure, such as would now be resorted to, might have saved the life of this patient, who died exhausted.

As to the employment of the hypodermic syringe for diagnostic purposes, it seems to me that if fluctuation is clear enough to warrant this, its aid is scarcely needed. It must not be forgotten that there are on record several cases in which fatal fecal extravasation has followed the puncture by this means of a herniated bowel.

With regard to the choice between the lateral and median incisions, I think that where the trouble is clearly in the right side of the abdomen, this is the proper surgical entrance. If there is no necessity for opening the peritoneum, it is certainly sufficient. And if there is such necessity, a lateral incision eight inches in length, such as is recommended for other purposes by several surgical writers, will give abundant access.

I would suggest that in women a vaginal examination may enable us to explore the iliac regions as well as the ovaries and tubes.

Dr. W. W. Keen said: I do not wish to be understood as advocating indiscriminate laparotomy in cases of peri-cæcal inflammation. I attempted to draw a distinction between those cases in which the pus is evidently in the iliac fossa, where the lateral incision is the proper one, and those cases in which examination by the rectum, and the vagina in women, shows that the pus has not been limited to the iliac fossa, but is in the cavity of the pelvis, where a median laparotomy is the better operation.

Dr. C. Wirgman said: I rise merely to emphasize one symptom mentioned by Dr. Pepper, and that is, the extension of the pain into the genitals. I had one case in which the pain radiated down the inner and outer aspects of the right thigh. In that case, which terminated fatally, the autopsy showed a concretion, but no foreign body. I had cautioned the utmost quiet. The patient was, however, a restless child, and on the eighth day flung himself from one side of the bed to the other. This was at once followed by excruciating pain, for which it was necessary to administer ether.

Dr. Musser said: I have but a word to say in conclusion. I do not deny that typhlitis occurs. I wished simply to emphasize the relative importance of appendicitis as compared with typhlitis. Typhlitis may occur just as inflammation in other parts of the colon may.

I am glad that Dr. Osler referred to the relations of the peri-cæcal abscess to the peritoneum. In my hurried remarks, I neglected to mention it. It must be borne in mind that the danger of a peri-cæcal abscess depends entirely upon its relation to the peritoneum. When intimately connected with it, or rupturing into the peritoneal cavity, the danger becomes imminent.

MEDICAL SOCIETY OF THE COUNTY OF NEW YORK.

Stated Meeting, December 26, 1887.

The President, Laurence Johnson, M.D., in the chair.

Dr. J. S. Warren read a biographical sketch of the late Dr. William M. Chamberlain, whose name had become connected with obstetrics and gynæcology.

Dr. G. H. Fox read a paper on

The Value of Resorcin in the Local Treatment of Acne.

Certain cases of acne, he said, could be treated successfully almost solely by hygienic measures, while others required some local applications. The former class included cases in which the disturbance was principally a vascular one; the eruptions on the face were not numerous, and when one tried to press out the comedones the skin was made worse; the face became flushed after eating and on slight excitement. The second class of cases were of an indolent nature; the skin was thick, dry or greasy; there were numer-

ous comedones. In these, dietetic and general hygienic measures alone would not cure; it was necessary to make some local stimulating application, and of this kind there were many. There were the sulphur and the mercurial ointments and lotions, but green soap he regarded as much better than these. But more efficient still was the remedy suggested by Dr. Metcalf, chrysarobin. To this, however, there was a strong objection in its discoloration of the skin and in its odor. Having the same effect, but not possessing its objectionable features, was resorcin. This remedy applied to the skin had an effect similar to carbolic acid, in that it caused a benumbing sensation, was more or less a caustic according to its strength, and in finally causing the thick epidermis to come away, leaving a thin, new skin.

Dr. J. Leonard Corning then read a paper on

The Treatment of Chorea by Cerebral Rest.

In this paper the author first reviewed briefly the history of chorea, its symptoms, its causes, and then gave its treatment, more particularly that by cerebral rest. Most of these patients, he said, were children of whom their parents expected much; who thought they possessed superior intellectual powers, and did what they could to stimulate them to thought and to study. They seemed to be possessed with the idea that a person in order to think must be acquainted with all the thinking which had been done by anybody else, and these nervous, excitable children were given numerous and difficult studies which an adult could hardly master. Choreic movements could be generated by stimulation of the gray matter of the cord, particularly of the posterior portion, and of the gray matter of the brain, particularly of the basic ganglia and cortex. As there was more or less disturbance of mind in these cases, and as the cortex was conceded to be the seat of the mind, it could be inferred that the cortex was disturbed in its functions in chorea. Dr. Corning had found that cerebral rest was the important object to be obtained in these cases, and this could take place only with the prolonged abolition of consciousness in sleep. Sleep could be secured by habit, for persons who were accustomed to take but a limited amount could, by accustoming themselves thereto, spend twelve or sixteen of the twenty-four hours in sleep. But this habit could not be at once established in choreic children; and in leading them up to the ideal point of cerebral rest he gave them bromides in increasing doses, and when the hour for sleep arrived they were put in a darkened room, away from light and noise. He also employed galvanism to the head. A rubber band was first placed around the scalp to render it anæmic, and ice water was also applied. A farinaceous diet was recommended in most cases. He did not always employ compression of the carotids. He gave arsenic, in the form of Fowler's solution, in increasing doses three times a day, and had in some cases carried it up as far as eighteen drops at a dose. Where peripheral irritation existed, as in the form of a phimosis, it should be removed.

Dr. David Webster spoke of the influence of errors of refraction and of insufficiency of certain sets of muscles of the eyes in causing chorea, and said he had benefitted or cured some cases by measures directed to the correction of those difficulties. But he thought it was claiming too much to say that all cases of chorea were due to any one sort of peripheral irritation.

Dr. Koplik had practiced cerebral rest much in the manner described by the author, with advantage in cases of chorea.

The President had seen two cases of chorea which he could justly attribute to an attack of rheumatism. The patients being run down in health, he would not think of giving farinaceous, but rather nitrogenous food. He would not recommend bromides in all cases, for they did harm in some by deteriorating the quality of the blood.

Dr. Carpenter had seen one case of chorea of such severity as to lead to a fatal issue. Eminent writers were so nearly equally divided on the question of the value of the arsenical treatment that we were left in doubt with regard to it. Certainly it could not be considered as a specific.

—Drs. Crook and Son, of Northfleet, have had marvellous results in the treatment of diphtheria, even when apparently hopeless, by the administration of a solution of *ferri et ammonii citras*, one part in eight of water, of which small doses were exhibited every two hours. In cases where the age gave no control, about half a drachm was allowed to slowly trickle down the throat. Where the patient, of about ten years, was able to guide the swallowing, a drachm of the solution was used with marked and rapid effect. Under this treatment they have not lost a case, and they consider that it deserves a generally extended trial.—*Quarterly Therapeutic Review*, Oct. 1, 1887.

Hospital Notes.

MATERNITY HOSPITAL OF PHILADELPHIA.

SERVICE OF BARTON C. HIRST, M.D.

Ischio-rectal Abscess Recurring with every Labor; Fœtus showing both Sacral and Cervical Spina Bifida.

The following case is of some interest, from the rather rare nature of the complication in the puerperal state, and from the very unusual deformity presented by the fœtus: namely, a cleft spine and meningocele involving the cervical vertebræ, as well as a spina bifida in the usual situation, dividing the sacral bones.

Mrs. McD., thirty-five years old, who had had eight children, gave birth to a premature stillborn infant in the eighth month of pregnancy, which weighed four and a half pounds. Occupying the whole length of the neck behind was a fluctuating tumor, which on dissection proved to be a meningocele, arising from a cleft in the cervical vertebræ. The exact number of bones involved is not given in the notes taken more than a year ago. Over the sacrum was another very large meningocele. The woman, being questioned, confessed that she had been infected with syphilis some years before. The puerperal state was uncomplicated until the tenth day, when the temperature rose to 100.8°, and the woman complained of pain about the anus. Examination then showed an area of redness and induration to the left of the anus. A free semicircular opening around the border of the sphincter ani was made, dressing forceps and grooved director were pushed up along the rectum about an inch, the abscess was opened, and about two ounces of very fetid pus evacuated. No communication between the abscess and the bowel could be discovered. The temperature fell at once, and the woman made a speedy recovery. She positively declared that, after every preceding confinement, the attending physician had been obliged to open an abscess in this same region: a statement which was supported by numerous old linear scars about the anus.

—Dr. R. A. F. Penrose has resigned the Professorship of Obstetrics and the Diseases of Women and Children in the University of Pennsylvania. This resignation is to take effect at the close of the current session.

PERISCOPE.

Curious Vaso-motor Phenomena of Typhoid Fever.

Dr. Angel Money, in the *Lancet*, December 3, 1887, says that, in many cases of typhoid and rheumatic fever, curious vaso-motor phenomena may be detected in the skin; and these, he thinks, may be grouped in one or the other of the following classes. In the first class he places the spontaneous vaso-motor phenomena, by which he means such as may be witnessed without further irritation or stimulation than that which attends the mere exposure of a surface of the body or limb on which observation may be made. If it be the surface of the abdomen, this may be found for the most part of a pinkish hue, such as tends to obscure the presence of rose-spots, if such be present; but, scattered here and there through the red tint, may be seen areas of whiteness, which present a distinct and striking contrast with the general tint, and are, moreover, characterized by varying in distinctness, being whiter or less white at one moment than at the preceding or succeeding moment. If to such a skin, under these circumstances, the additional condition be added of a slight mechanical, electrical, or thermal stimulation, it further happens generally that the stimulated area or line turns white or ivory tinted after the lapse of a rather long latent period, which varies in different cases and at different times, for unknown reasons, but is generally measurable by seconds. The whiteness is not strictly limited to the irritated section, but spreads away from the part stimulated, and in a gradual, decreasing fashion. Moreover, the pallor does not appear abruptly after the period of latency; but the pinkness of the skin gradually gives way to whiteness, and the changing hue is very perceptible. Thus, both in space and time, the phenomenon has a graduation and a duration which are, comparatively speaking, of slow course, and remind one rather of the contraction of smooth, plain, nerveless muscular fibre than the rapid, sharp contractions of the well-nerved voluntary muscle. He states by way of caution that too much stress should not be laid on this feature, although he thinks that it suggests the independence of the phenomena on the nervous system, and their dependence on the mere living undifferentiated protoplasm of the walls of the capillary vessels.

It will also frequently, but not always, be

found that exposure of the skin of the arm and forearm in the same subject presents a contrast with the previously or simultaneously exposed surface of the abdomen, the general tint being white, with irregular patches, sometimes streaks of pink or darker red. When this contrast is evident, and occasionally when there is no such general and spontaneous dissimilarity of appearance, mechanical, and sometimes (always?) electrical and thermic irritation of the skin of the arm will be followed, after a similar, but perhaps generally a trifle shorter, period of latency, by the gradual development of the *tache cérébrale*, or red streak, having the usual characters of that phenomenon. Sometimes the surface of the arm has a general pink tint on first exposing it to the atmosphere, and this may rapidly change to white; but the color of the written characters thereon may be deep red. The contrast in color may be still more remarkable, even in the same case: the writing may be white on the surface of the abdomen, red on the forearm, white on the legs. The author lays considerable stress on the fact that the temperature of the skin and of the body is usually high in cases which present these vascular phenomena; and further, he has most generally observed them in full perfection when the skin has not been perceptibly sweating. But neither increased heat nor especial dryness of the skin are necessary to their production, for the author states that he has seen them very well marked in cases of epilepsy and chorea of uncomplicated and afebrile type. The majority of cases in which these observations were made showed cerebral disturbance, delirium being frequently present at night, for the most part. Nevertheless, the observations were usually made during the day-time, and when the intellect of the patient did not seem to be abnormally affected.

Treatment of Eczema and Psoriasis.

In the *Lancet*, December 3, 1887, Dr. A. S. Myrtle, of Harrogate, a well-known watering-place in England, declares that forty years' experience with eczema and psoriasis has led him to the belief that the former disease is spread by scratching. He goes so far as to say, that if itching is prevented, scratching will cease, and the eczema will be cured. He relates several cases of eczema and psoriasis of a most aggravated type, which were sent to him to undergo treatment with the natural sulphur waters of Harrogate. The author declares that all ointments are filthy and injurious in the eczema which is characterized by diffuse areas with raw surface, which exude serum and pus, and are encrusted with scabs, which leave angry sores on their removal. Dr. Myrtle's treatment, in such a condition, is to employ alkaline sulphur baths, at a temperature of 98° F., once a day, gradually lengthening the duration of the bath. Following the bath, the body is carefully dried, and the affected areas covered with fine sheet cotton-wool, medicated with a preparation of coal tar. His treatment for psoriasis is substantially the same, except that he directs the patient to remain in the bath for as long a time as possible without being chilled, and orders the bath at as low a temperature as the patient can bear. He also orders internally a course of sulphur and chalybeate baths, and expresses the belief that painting the old-standing patches of psoriasis with naphthaline tincture, after the sulphur bath, gives most satisfactory results. This latter application may also be used in the old-standing patches of eczema. He regards a quinine lotion as by far the best preventive against recurrent attacks of eczema.

Treatment of Quinsy.

Dr. W. E. Green, in the *British Medical Journal*, 1887, p. 1151, strongly recommends the following prescription for quinsy:

℞ Tr. aconiti..... 8 parts
Tr. guaiaci.....15 "
Glycerinæ..... 7 "

M.—Dose for an adult, 20 drops every hour until distinct improvement appears, and after that every four hours.

The dose for children is smaller in proportion to their age. Dr. Green mentions of the case of an infant, only eight months old, with quinsy, to which he gave a drop and a half of tincture of aconite every hour for a day and a half, without any ill effect, and which recovered.

Congenital Syphilis Causing Amyloid Disease.

At the meeting of the Pathological Society of London, November 15, 1887, Dr. Hale White (*Lancet*, November 19, 1887) showed specimens of congenital syphilis which had caused lardaceous disease of the viscera, gummata, and fibrosis of the liver, and chronic peritonitis. The patient was a girl seven years old, both whose parents had syphilis, and who herself presented most of the signs of a congenital syphilis. The liver could be felt with a hard rounded edge just above the

iliac crest; the spleen reached below the umbilicus; there was some pain and tenderness in the abdomen; the left eye showed disseminated choroiditis and optic neuritis; the glands in the right axilla were enlarged, and there was a painful node over the head of the tibia; the urine was albuminous, and this decided the diagnosis in favor of lardaceous disease. She improved under treatment, but ultimately succumbed to an attack of acute tonsillitis. The liver weighed 61 oz.; it was hard, rounded, with radiating fibrous depressions all over it; there was also some cirrhosis. At the anterior part was a gumma the size of a walnut; it (the liver) was extremely lardaceous throughout, as was also the spleen, which weighed 16 oz. The kidneys weighed 12½ oz., and both showed tubal nephritis and lardaceous disease. The small intestine and cervical glands were slightly lardaceous; there were several bands of fibrous tissue indicative of old peritonitis. There was no sign of there ever having been any suppuration. The lardaceous deposit was seen very well under the microscope. The case showed three very rare manifestations of congenital syphilis: lardaceous disease, chronic nephritis, fibrous scars and gummata in the liver, in addition to cirrhosis.

Osteoclasis for the Correction of Deformities.

Dr. Dillon Brown, in a paper in the *Medical Record*, December 3, 1887, after stating that osteoclasis was known to the ancients, but that it never gained popular favor until the introduction of ether and chloroform, says that it is just as effective in proper cases as osteotomy, and avoids the dangers from pyemia, secondary hemorrhage, and other accidents which may follow a serious cutting operation. He regards osteoclasis as useful for the correction of: 1. Rachitic deformities of the extremities. 2. Deformities following badly united fractures. 3. Articular deformities resulting from bony anchylosis. 4. Deformities following old dislocations. 5. Certain obstinate forms of club-foot.

With respect to the performance of instrumental osteoclasis, he says that without doubt a certain, and possibly a large, proportion of rachitic deformities of the extremities recover without either mechanical or surgical interference. In no case should constitutional treatment be neglected—good hygienic surroundings, proper food, and cod-liver oil. The hypophosphites are good, theoretically. On this account he would not apply the clumsy mechanical supports in very young children unless the deformity was very much exaggerated, but depend upon general treatment and frequent daily attempts at correction with the hands. The splints do harm, not only by altering the space of the soft pelvis, but by interfering with the action of the already weakened muscles. If the deformity increased in spite of this, he would then apply some mechanical support.

As soon, however, as the bones become eburnated, operative interference is necessary to correct the deformity, and osteoclasis seems to him much preferable to osteotomy. It is just as effective, besides meeting the same indications in a safer and simpler manner. It has been practically demonstrated that the great but temporary pressure brought to bear upon the soft tissues by the osteoclast does no harm, and it has been repeatedly shown, in experiments on the cadaver, that complete control can be had over the point of fracture. In about thirty fractures which he has made with the osteoclast upon the cadavers of children, including the tibia and fibula, the femur and the humerus, the fracture was, without exception, opposite the pressure pad of the instrument; it was practically transverse, and in only one case was there any comminution.

He prefers for bow-legs Rizzoli's osteoclast as modified by Dr. A. T. Cabot, of Boston.

The dangers following osteoclasis in the treatment of the bony anchylosis sometimes resulting from old dislocations are severe enough to make great violence unjustifiable, and warn the surgeon to be cautious in its use. There is not only the danger of separation of the epiphysis, or of fracture near the joint, leaving the limb in a worse condition than before; but large vessels have become adherent to the capsule or the periosteum of a displaced bone, and fatal hemorrhage has resulted from their rupture in attempts to reduce the dislocation. In some cases the muscles have become contracted, and it is necessary to divide their tendons before attempts are made to break up the anchylosis.

In concluding his paper, the author desires to state clearly, that he does not recommend operative measures in rachitic deformities of the extremities until the bones have become eburnated, except in that class of dispensary patients in which the surgeon must correct the deformity rapidly or have no chance to treat the patient.

The principles which guide him in the treatment of these cases are:

1. In children under two years of age, in

which the deformity is not exaggerated, the expectant plan, possibly with frequent daily attempts at correction with the hands.

2. In older children, in which the bones are yet soft, some form of mechanical support.

3. As soon as the bones become eburnated, osteoclasis or osteotomy.

4. Osteoclasis is to be preferred in all cases of deformity near the middle of the long bones, in a large proportion of cases of knock-knee and other deformities near the joints, and only rarely in cases of bony anchylosis and club-foot.

Theory and Practice of the Operation for Radical Cure of Hernia.

W. T. Stoker, Prof. of Anatomy in the Royal College of Surgeons, Ireland, in a paper on this subject read before the British Medical Association, at Dublin, in August, 1887, and published in the *British Medical Journal*, Dec. 3, 1887, says that the open operation is beating other operations out of the field, because it offers certainty and precision, and because it has become a safe operation under the teachings of Lister. He, however, raises his voice against the practice of securing approximation of the walls of the inguinal canal by means of sutures of silver wire; because, when once the hernial canal is closed and consolidated, they become sources of possible inconvenience or danger, or irritation, and also interfere with subsequent application of an artificial support. He declares that the best and most permanent closure depends on the exudation and organization of lymph, and the consequent consolidation and drawing together of the parts, which is assisted by such a plug as the twisted sac is capable of affording. He has adopted the plan of twisting the sac in all his later operations. The following is his method of operating:

The sac is exposed by an incision extending downwards and inwards from the external abdominal ring as far as may be necessary. In ruptures in infants, one inch and a half is generally a sufficient length; in adults or in youths with a large rupture, it may require to be two inches and a half or three inches long. The sac having been exposed, must be carefully and laboriously disconnected from the elements of the cord. This is often a very tedious process, and is best effected with the director and a pair of small scissors. In congenital and infantile herniæ, which constitute the bulk of those operated on in young subjects, the isolation of the sac is often particularly tedious. As soon as the sac is well separated as high as the external ring, and for an inch or so downwards from that point it should be included in two catgut ligatures and divided between them. The lower ligature serves to close the tunica vaginalis if it is a part of the sac, as it generally is in congenital cases, while the upper one seals the peritoneal cavity. If the sac should be of great size, as much of the distal portion of it as is advisable may be removed. The proximal portion of the sac is then seized and twisted, the torsion being carried to such a degree that a sense of resistance is felt. It is difficult to lay down a rule as to the amount of force to be employed in twisting; the object of the operator should be to secure as complete closure of the sac, as close approximation of the walls of the canal, and as much tension and obliteration of the inguinal pouch as is possible, without incurring the danger of the contorted sac sloughing from too severe treatment.

Two sutures of silk are then introduced. Each is made to pass through the pillars and walls of the canal, and to transfix the twisted sac between the inner and outer walls. The sutures should be brought through the skin about an inch from the incision on each side, and the ends of each tied "button" fashion over a leaden plate. Deep apposition is thus secured, and the twists are retained in the sac. Points of interrupted suture are then inserted in the skin, and the wound dressed antiseptically. In very young children a single deep suture may suffice.

He closes his paper by summing up his opinions on the subject of this operation in the following propositions:

1. That, particularly in young children, operation should only be undertaken when minor measures have failed or are inapplicable.

2. That on the ground of its safety, certainty, and precision, the operation by dissection is to be preferred.

3. That twisting the sac is a safe and efficient aid to the operation.

4. That sutures, so far as their use in closing the canal is concerned, serve but a temporary purpose, and that their chief end is to excite a sufficient lymph exudation.

5. That sutures, therefore, need not be introduced tightly, and that trouble from testicular swelling may be thus avoided.

6. That the permanent retention of wires is unnecessary, possibly hurtful, and bad in theory and practice.

7. That while a uniform support to the inguinal region is desirable for some time

following operation, it cannot safely be afforded by a truss furnished with a pad.

It is proper to state, in this connection, that Kendal Franks, surgeon to the Adelaide Hospital, Dublin, at the same meeting of the association at which Mr. Stoker's paper was read, strongly advocated the use of silver wire for sutures. He says he has used it in all his cases except one, a femoral hernia, and regards Mr. Stoker's objections to it as theoretical and unsupported by practical experience.

Treatment of Acute Nephritis in Children.

E. Henock, in a paper on the affections of the kidney in children in the *Charité Annalen*, xii, 1887, S. 638, which is reviewed in the *Centralblatt f. d. med. Wissensch.*, November 5, 1887, says that the treatment of all kinds of acute nephritis is the same. He remarks, by way of caution, that, in the estimation of the therapeutic results of the remedies which have been employed, one must bear in mind that acute nephritis, upon whatever cause it may depend, has an inherent tendency to spontaneous cure. We have, he says, no direct means of holding in check the extension of the disease; but the natural tendency to cure can be materially assisted (1) by absolute rest in bed from the very moment in which the urine becomes albuminous until the albumin entirely disappears; (2) by a milk diet, rigidly and persistently carried out. Milk and farinaceous substances cooked in milk are to be the only food; soup is to be given only in small quantity, meat not at all. Wine is to be employed only when collapse threatens. It is advisable to let the patient drink three or four wineglassfuls of Biliner or Wildunger mineral water daily; and it is also proper to give a mild purgative. Under this simple treatment a large number of cases of acute nephritis will recover in from eight days to a few weeks. Even a slight œdema of the eyelids and ankles is no reason to abandon this method; but more energetic measures are to be taken if the œdema becomes more extensive. Still, one should guard against the employment of stimulating diuretics in these cases, given with a view of increasing the flow of urine, which is always markedly diminished in these patients. On the other hand, purgatives are to be recommened; and, in addition to purgatives, warm baths, followed by sweating. The result of this method depends undoubtedly upon the production of copious perspiration. If perspiration does not occur, then the baths have no effect. It is best to begin the baths with the water at a temperature of 95° F., and bring it gradually to a temperature of 97°–99° F. by the addition of hot water. After the baths, which may last from ten to fifteen minutes, the patient is enveloped in warm woollen blankets until sweating occurs.

The bath is given once a day, and under some circumstances may be persisted in for weeks. Serious injury is never caused by this treatment; only in some rare cases the quantity of blood in the urine is increased. The bath must then be discontinued, and treatment confined to warm drinks. The complication of nephritis with diseases of the lungs or of the heart does not contraindicate the employment of the baths. Other means of exciting sweat, such as wet packs and pilocarpin, do not, on the whole, do as good service in children. It rarely happens that pilocarpin excites more perspiration than the baths, and in such cases it may be employed with proper caution. Other remedies, such as local bloodletting, astringents, etc., do no good at all. In uræmia, pilocarpin not only does no good, but may even be dangerous by provoking collapse. On the other hand, an energetic antiphlogistic treatment achieves rapid and indisputable results; but, where heart failure is threatening, a stimulating treatment is to be employed instead of it.

Transmission of Tuberculosis by Expired Air and by the Atmosphere.

In the *Revue de Médecine*, No. 7, 1887, Cadéac and Malet report that the expired air of phthisical patients, that is to say the water of condensation obtained from it, was neither able to produce tuberculosis in three healthy Guinea pigs, nor in three affected with bronchial catarrh. Nineteen tuberculous rabbits or Guinea pigs were placed in a box, which was divided into two by a lattice work; into the adjoining compartment were placed twelve rabbits or Guinea pigs, in which an artificial bronchitis had been developed: the last-named animals remained free from tuberculosis after two or three months. The authors conclude from all these experiments that the expired air of phthisical patients is entirely harmless. It is otherwise with the air of sick rooms in which is present the dried dust of phthisical sputum or other possible impurities. With the water of condensation of such air, they were successful in obtaining tuberculosis in animals by infection in two cases out of twelve trials.—*Centralblatt f.d. med. Wissensch.*, November 5, 1887.

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CREASOTE IN PHTHISIS.

In the REPORTER, June 18, 1887, we called attention to the recommendation of SOMMERBRODT, of Breslau, to use creasote in the treatment of phthisis. The good results which he obtained with this medicament have encouraged employment of it in this city, with results which appear to justify his convictions of its usefulness—especially in incipient phthisis. This drug has been given by a number of other medical men, some of whom have been disappointed in its results. In a recent paper, in the *Berliner klin. Wochenschrift*, Nov. 28, 1887, Sommerbrodt states that this disappointment is probably attributable to the fact that the drug was too timidly used. His own experience leads him to the conviction that it should be given in considerable quantities, and pushed almost to the limit of tolerance. He thinks that "the more creasote can be borne daily, the better its effect." He administers it in capsules, containing three-quarters of a grain each. Of these he gives one capsule three times a day for four days; then two capsules three times a day for four days more; then three capsules three times a day for four other days; and so on until he reaches a dose of five capsules three times a day. This makes a maximum of about twelve grains a day. This quantity he finds is usually borne very well, and proves very beneficial to his patients.

Sommerbrodt's opinion of the value of creasote in phthisis is shared by Gimbert, who has said: "If we are asked to define the limits for the employment of creasote in pulmonary phthisis, we would be tempted to reply that we see indications for it everywhere, and contra-indications nowhere." On the other hand Fräntzel says: "Most cases of tuberculosis apply for treatment at a period in which the creasote treatment holds out no promise of success."

It is probable that the truth lies between these two extremes; and we think there can be little doubt that creasote is calculated to do good in a considerable number of cases of phthisis, especially if it be used with some courage, as Sommerbrodt advises.

WASHING OUT THE STOMACH FOR ILEUS.

The treatment of internal obstruction of the bowels has been so much discussed of late that it seems almost tedious to recur to the subject. But, as these obstructions are by no means rare, and as they are apt to occur at most unexpected times, it is important to be as fully prepared as possible for so trying an emergency.

The tendency now-a-days is so strongly toward early surgical interference in cases of ileus, that it seems worth while to call attention to a measure within the reach of every medical man, which often does great good, and sometimes effects a cure. This measure is washing out the stomach. To carry out this procedure it is only necessary to introduce a soft œsophageal tube into the stomach, and to pass through it, with the aid of a funnel, a quantity of water, which will return, if the upper end of the tube be depressed, so as to siphon-out the contents of the stomach.

This method may be adopted—indeed it may be said it ought to be adopted—in all cases of sudden obstruction to the bowels, coming on with the usual symptoms of pain,

nausea, vomiting, and more or less collapse. If promptly appealed to, washing out the stomach will generally alleviate the distressing symptoms, and it may be followed by recovery. If this happy result do not follow, the procedure may be expected to improve the chances of a favorable issue after a subsequent laparotomy, if this be undertaken. The effect of washing out the stomach in cases of ileus is to diminish the contents of the abdominal cavity; to lessen the tension of the bowels; to quiet violent peristalsis; to stimulate the splanchnic nerves; and to remove the cause of the reversed peristaltic movements of the intestine. The latter point is one of the most important in the whole process.

In every way, then, it appears desirable to adopt this method before proceeding to more heroic measures; and we recommend it to the consideration of our readers as part of their preparation for one of the most painful and most dangerous events which can occur in their practice.

SELF-PROTECTION AGAINST BACTERIA.

The question why, if bacteria are almost omnipresent, they do not depopulate the world, is answered by the assertion that they do not thrive in unsuitable media, and that, for their propagation in the human body, its tissues must be in a condition favorable to the growth of the germs which gain an entrance to it. But, in addition to this fact, it has been observed that the blood is not only ill-suited to the growth of many micro-organisms, but even toxic to them.

Some time ago, Wyssokowitsch advanced the theory that bacteria, injected into the blood-current, disappear because they become entangled in the parenchymatous tissue of various organs, and are destroyed (or devoured) by the endothelial cells of the blood vessels.

The correctness of this theory might be doubted from the fact that bacteria often thrive and multiply in the parenchyma of such organs as the spleen. A more recent theory is that the blood itself exercises a repressive or fatal influence upon bacteria. Josef von 'Fodor, in the *Deutsche Med. Wochenschrift*, No. 34, 1887, describes a series of experiments, the results of which strongly support this theory. He took blood from the heart of a rabbit under suitable precautions, conveyed it into a tube, and inoculated it with anthrax bacilli, controlling this experiment by a similar inoculation of tubes containing gelatine. From all these tubes specimens were taken after intervals varying from a quarter of an hour to an hour, and were tested by cultures in fresh gelatine. By this method Fodor ascertained that the number of bacilli decreased rapidly in fresh blood, and seems to have proved that the blood itself is an unfavorable soil for the bacilli of anthrax at least.

This fact is as reassuring as it is interesting, and explains to a certain extent the immunity from disease which the most of the animal kingdom enjoy in the presence of a host of micro-organs supposed to have the power of propagating disease. It tends to explain the rarity of disturbances due to germ-infection, and the fact that infection is by no means common in surgical operations conducted without specific aseptic or antiseptic precautions.

It is a good thing for mankind, and all animals, that their bodies do not offer an unresisting or propitious harbor to the germs of disease; but that the vital fluid which circulates through their blood vessels has the power of rendering inert or destroying very considerable numbers of these ubiquitous enemies to life and health.

COLLECTIVE INVESTIGATIONS IN REGARD TO DRUGS.

It is announced by *The Pharmaceutical Era* that it proposes to institute a series of collective investigations, selecting for each month a particular query, inviting answers from all who are willing to contribute, and promising to publish the substance of the answers in succeeding numbers of the *Era*. When necessary the *Era* will supply the requisite material for pursuing the investigation.

The first subject proposed for investigation is Dr. Squibb's "physiological" test for the

strength of preparations of aconite—the question being: Is there any uniformity in the susceptibility of different individuals to the peculiar impression produced by aconite on the nerves of the tongue?

The subject proposed for the succeeding month is: Should abstracts be retained in the U. S. Pharmacopœia? Do physicians prescribe them, and are pharmacists in favor of retaining them?

The *Era* justly remarks that these proposed changes in the pharmacopœia should be thoroughly discussed in advance, and desires to include such matters in its plan of collective investigations, hoping to hear from physicians, as well as druggists, in this investigation, and in regard to any topic in which their interests are concerned.

Those pertaining to the manipulations of practical pharmacy will perhaps elicit results of the greatest interest and value, but there are also a multitude of technical and scientific questions which may be discussed with profit. Pharmacology will claim a share of attention, but obviously it can be only the more pronounced characters of drugs that can be considered in such a method. Thus, it is possible perhaps to collect statistical information with regard to such a question as the relative activity of cascara sagrada and buckthorn bark, and even to obtain the practical verdict of physicians, as shown by their prescriptions, regarding the relative merits of these drugs as therapeutic agents. And information collected from observers, the majority of whom may be assumed to be unprejudiced, cannot but be of very great value in such cases as this. Each month the *Era* will announce the subject for discussion in the two succeeding numbers.

We shall look forward with some interest to see how this plan will operate. It has promise in it of much usefulness; and, if it fulfils the promise, we will not delay to lay before our readers the results of the enterprise of the *Era*.

PERICÆCAL INFLAMMATION.

Our readers will observe that in this number of the Reporter we have reproduced entire three short addresses delivered before the Philadelphia County Medical Society, at a meeting devoted to the subject of pericæcal inflammation.

We would not care to give so much space to one subject, were it not that it is a very important one to every physician, and that in these three addresses the nature, diagnosis and treatment of so-called typhlitis and perityphlitis are described in an admirably clear and concise manner, by men abundantly competent to speak in regard to them.

In calling special attention to this matter, we desire also to commend to other medical societies the plan adopted on the occasion referred to. A subject was selected several months before the time chosen for its discussion; three men were asked to take up each a special phase of it, and the members of the Society were made aware of the fact in time to prepare themselves to join in the discussion or to listen to it intelligently. The result was an unusually large and interesting meeting and a rarely satisfactory presentation of the subject on hand.

LANOLIN AND BACTERIA.

Dr. A. Gottstein, of Berlin, has recently made some interesting experiments in regard to the behavior of pure lanolin toward bacteria (*Berliner Klin. Wochenschrift*, Nov. 28, 1887), and has found that lanolin will not support the life of bacteria, and that bacteria do not penetrate a thin layer of lanolin. The reverse of this is true in regard to lard and suet, in which he found bacteria to thrive, and through which they were able to penetrate.

MEDICAL SOCIETY OF THE STATE OF PENNSYLVANIA.

The thirty-ninth annual session of the Medical Society of the State of Pennsylvania will be held in Philadelphia, beginning Tuesday, June 5th, 1888. In order for the proper assignment of places on the programme, those who propose to read papers are requested to send the titles thereof, not later than April 15, to the chairman of Committee of Arrangements, Dr. John H. Packard, 1924 Spruce Street, Philadelphia.

Book Reviews.

[Any book reviewed in these columns may be obtained, upon receipt of price, from the office of the Reporter.]

ANATOMY, DESCRIPTIVE AND SURGICAL. By HENRY GRAY, F.R.S., etc. Edited by T. Pickering Pick, F.R.C.S., etc. New American edition, from the 11th English edition. Thoroughly revised and re-edited by William W. Keen, M.D., etc. Royal 8vo, pp. 1100. Philadelphia: Lea Brothers & Co., 1887. Price: cloth, $6.00; leather, $7.00; with colored plates, cloth, $7.25; leather, $8.25.

This new addition of "Gray's Anatomy" has been gone over carefully by Dr. Keen, whose studies in anatomy and whose experience in teaching it make him peculiarly well fitted for such a work. As a consequence, this edition is superior in a number of respects to its English predecessor. This is seen not only in the parts which Dr. Keen has filled out from his own observation, but also in those which he has edited in the stricter sense of the word.

The book, as a book, is very handsome, and we regard it as an especial advantage that a certain part of the edition has been printed with the blood vessels and the nerves colored, as well as the attachments of muscles upon the bones. This not only makes the illustrations more attractive to the eye, but tends to impress what they represent more forcibly upon the memory.

This design was, we believe, original with Mr. Luther Holden, who years ago produced the first edition of his Osteology with the intention of following it up with a work on general anatomy. He was deterred from the execution of this project by the appearance and success of "Gray's Anatomy," which has so occupied the field as a book for students, that of late Mr. Holden seems to have abandoned his original intention, since he has consented to have appended to a work which in that case would be a rival, to his excellent manual on "Medical and Surgical Landmarks."

A PRACTICAL TREATISE ON MATERIA MEDICA AND THERAPEUTICS. By ROBERTS BARTHOLOW, M.A., M.D., LL.D., Professor of Materia Medica, General Therapeutics and Hygiene in the Jefferson Medical College of Philadelphia, etc. Sixth edition, revised and enlarged. 8vo, pp. xxiv, 802. New York: D. Appleton & Co., 1887.

In his preface, the author says: "This edition of my treatise contains much new matter. The domain of pharmacology is rapidly enlarging by the contributions of chemistry and by the new remedies brought forward by dealers with a view to profit." This sentence illustrates one of the most striking characteristics of the book before us—its inflated verbiage, which perhaps conveys the author's meaning, but in a vague and somewhat incoherent way. Another illustration of it may be found in the sentence in which Dr. Bartholow defines his position in regard to the terms "hypodermic" and "hypodermatic," where he says what he certainly does not mean. It is curious to find an author who is so much concerned about a comparatively innocent term, using so monstrous an one as "urino-genitals" to indicate a class of remedies, or so awkward an one as "stomachal administration."

The scientific value of this book is considerable, in spite of its defects of style. It contains a great deal of useful information, and seems to be abreast of the times. In regard to gleditschine, which was so recently vaunted as valuable addition to materia medica, the author shows great shrewdness in expressing a suspicion, the justice of which has since been fully confirmed.

We are inclined to think the author is a little too hopeful in regard to the effects of drugs in general, and too positive in his statements about them. Still, this very characteristic is probably the secret of the success of his book; for men like to be guided by those who have confidence in their own judgment, and who do not disclose to others any misgivings which they may have in their own minds.

THE RECTUM AND ANUS: THEIR DISEASES AND TREATMENT. By CHARLES B. BALL, M. Ch., Univ. Dub., F.R.C.S.I., etc. Small 8vo, pp. viii, 410. Philadelphia: Lea Brothers & Co. No date. Price, $2.25.

This is an excellent manual, prepared especially for the use of medical students, but calculated to be useful to all sorts of medical men. It gives a clear and very full account of the diseases and malformations of the lower bowel, and of the treatment adapted to each one. The author has studied carefully the best works on this subject, produced on both sides of the Atlantic, and adds to what he has gathered from them the results of his own experience. In questions which are still under discussion, such as the treatment of hemorrhoids by injections of carbolic acid and the best operation for cancer of the rectum, the views of Mr. Ball are, we think, sound and worthy of acceptance; and we can recommend his book heartily to our readers.

The illustrations—of which there are fifty-eight, including four colored lithographs—are for the most part very good. The lithographs are, like most of such illustrations in medical books, more striking than faithful to nature. The type is clear, and the volume, as a whole, convenient to handle, and easy to read.

Pamphlet Notices.

On the Treatment of Felon Without Incision. By L. Duncan Bulkley, A.M., M.D. From the *Journal of the American Medical Association*, July 30, 1887. 8 pp.

On the Existence of "Dermatitis Herpetiformis" (of Duhring) as a Distinct Disease. By L. Duncan Bulkley, A.M., M.D. From the *Journal of Cutaneous and Veneral Diseases*, April, 1886. 12 pp.

Contributions to Gynæcology. Fasciculus I. The Galvanic Treatment of Uterine Fibroids. By Ephraim Cutter, A.M., M.D., LL.D. New York: William A. Kellogg, 1887. 73 pp.

Diet in Cancer. By Ephraim Cutter, A.M., M.D., LL.D. From *Albany Medical Annals*, July and August, 1887. 33 pp.

—Dr. Bulkley says that for many years he has not incised a felon, nor used a poultice in its treatment. The method which has enabled him to pursue this course with satisfaction consists in giving a cathartic followed by Startin's mixture:—Sulphate of magnesia, ℥j; sulphate of iron, ℥i; dilute sulphuri

acid, f℥iv; syrup of ginger, f℥j; and water to make a four-ounce mixture. Dose, a teaspoonful, after eating. In addition to this, he gives calx sulphurata, ¼ gr., in a gelatine-coated pill, every two hours, and generous diet. For local treatment he envelopes the part in Hebra's diachylon ointment. His experience covers a number of cases which he estimates as "a dozen or more" in ten years.

—Dr. Bulkley recognizes the fact that there are diseases of the skin which cannot be exactly classified under any of the varieties designated in works on dermatology; and is inclined to recognize as a distinct group those for which Duhring proposed the name "dermatitis herpetiformis." But he thinks that the herpetic element is so slightly marked that "dermatitis pruriginosa" would be a better term. In this connection it may be noted that German dermatologists do not approve the attempt to introduce these terms in the classification of skin diseases.

—Dr. Cutter presents the histories of fifty cases of tumors, diagnosticated as fibroids of the uterus, upon which he and Dr. Gilman Kimball, of Lowell, Mass., have operated by electrolysis. Dr. Cutter uses strong currents and gets results which encourage him to advocate this method.

—The second pamphlet by Dr. Cutter contains an account of cases diagnosticated as cancer—most of them of the uterus, in which apparently much benefit was derived from pushing the use of food, especially flesh, eggs and milk. Many of these cases are interesting, and some are instructive. But we cannot but characterize as disgusting the author's pointing out his own wife as "Case IX," the details of which are described so fully that few women would care to have their names attached to it.

Correspondence.

Spontaneous Cure of Perityphlitic Abscess.

Ed. Med. and Surg. Reporter:

Sir:—Dr. Dittmer's case of laparotomy for chronic peritonitis, as given in the Reporter of Dec. 17, p. 809, reminds me of a case which I saw in 1857. I was called to a woman about 30 years of age, who had been under the care of an old eclectic who practiced in her neighborhood. He had become frightened at the free discharge of pus from an opening near the navel, and wished me to take the case. The old fellow was inclined to be patronizing, and to give me the benefit of his observation. He said that the patient had a "bealin' in the belly;" that he had been afraid that it was in the os uteri; but now, that it had "broke at the umbillis," he thought her chance was better. I found there was an abscess near the cæcum, with a free discharge of healthy looking pus from an opening at the right side of the umbilicus. I thought it was probably connected with the appendix; but, like the old doctor, I did not know much about it. Antiseptics were then unknown, and drainage-tubes not yet invented. So I prescribed tonics and no local applications except those required for cleanliness. The family lived ten or twelve miles from me. After visiting her a few times, I told them to report any change. I did not hear from her for six months, when I was again sent for. In the meantime the opening at the navel had healed, and another had formed directly over the head of the colon, and had that day discharged two lumps of hardened fecal matter one-third of an inch in diameter. After this, my patient made a rapid recovery. Within a year she was delivered of a healthy child, and she is still enjoying good health. Yours truly, A. Ady, M.D.

Muscatine, Iowa, Dec. 22, 1887.

Chordee a Frequent Cause of Stricture and Chronic Gonorrhœa.

Ed. Med. and Surg. Reporter:

Sir:—Many cases of stricture and chronic gonorrhœa are the result of allowing a patient to be uninstructed in regard to chordee. Many patients with venereal disease are not obliged to rise at early hours, and therefore remain in bed after first awaking until the thoughts of the old haunts excite an erection. With chordee, not only this, but the usual prescriptions of balsam of copaiba and sweet spirits of nitre, etc., in large doses, cause a superabundant secretion of urine, with increased pressure upon the bladder. A patient, who has not been told of this, often lies abed until he is forced by an erection to get up and hold his penis in a cold water bath to reduce the erection.

If, however, all our patients were instructed at the outset to rise early or on first waking, and to immediately empty their bladders, many cases of chordee would be avoided. Further, in gonorrhœa, each prescription should contain some remedy calculated to prevent erections during the congestive stage of clap. For in this condition the mucous membrane cannot stretch freely, on account of the high degree of inflammation, and cannot follow the expansion of the corpora cavernosa, so that small fissures occur, which are increased upon each succeeding erection, and become the sites of small ulcers and sacs, in which pus burrows. This, in my opinion, contributes in no small degree in the formation of strictures of the urethra. I have observed in cases in which chordee frequently occurred, were apt to be tedious and to run a chronic course, often terminating in gleet.

Too many physicians pay no attention to gonorrhœa, other than to give a prescription containing the usual formulæ of copaiba, nitre, etc., and the regulation sulphate of

zinc and rose-water injection, until some four months later the patient returns with gleet, stricture, and all that belongs to a neglected case of clap, saying he has had a tremendous struggle with chordee, balanitis, preputial ulcers, etc. My experience in about one hundred and fifty cases of this disease leads me to believe that patients with gonorrhœa should be kept under rigid rules until they have passed the inflammatory stage at least. Yours truly, C. F. Camp, M.D.

Barre, Vermont.

Pertussis and Jaundice.

Ed. Med. and Surg. Reporter:

Sir:—Some three months since the first case of whooping-cough appeared in this vicinity. A number of exposures were made before the nature of the cough was known. The most of the cases were mild; still a number of them were severe. A curious event occurred in the progress of the disorder, which was the appearance of jaundice, in nearly every case of pertussis; while many who had not the cough were afflicted with jaundice. The symptoms were nausea, vomiting, loss of appetite, and a slight rise in temperature. I ascribed the jaundice to gastro-duodenal catarrh, extending to the bile ducts. Under treatment the symptoms rapidly disappeared; without treatment, recovery was slow. In the treatment of the cough, only one remedy was used, and that with marked benefit, not only in apparently shortening the disease, but also in markedly lessening the paroxysms of coughing. This remedy was belladonna: the mother tincture, in half minim doses. The remedy was pleasant to take, and no child refused the small morsel, which has scarcely any taste but that of sugar. The doses were repeated about four times a day. To remove the jaundice and ameliorate the distressing symptoms, I gave nitro-muriatic acid, in small and repeated doses, in sugar and water, with a single tablet containing calomel, gr. $\frac{1}{10}$; podophyllin, gr. $\frac{1}{30}$; ipecacuanha, gr. $\frac{1}{8}$, at bed-time. Under this simple treatment the jaundice quickly disappeared and recovery followed.

There seemed to be something peculiar in the fact that these two diseases were almost always found in company. How to explain the fact satisfactorily, unless it was simply a coincidence, I am at a loss to know. The gastro-duodenal catarrh afflicted nearly every child in the family, and it seemed as if it was endemic or possibly contageous. The late fall and early winter have been very mild, and the temperature quite high for the season, as well as even, with rather a lack of humidity than otherwise. If any one else can see anything interesting in these notes, and can enlighten me, I shall be pleased.

Yours truly, A. D. Bundy, M.D.

St. Ansgar, Iowa, Dec. 20, 1887.

Physician and Pharmacist.

Ed. Med. and Surg. Reporter:

Sir:—I have read the article in December's Reporter, by W. C. Eustis, M.D., berating the pharmacist for exorbitance, and, in fact, for *being* at all. He tells us that the pharmacist could easily be dispensed with, and then, in turn, advises his brother M.D. to keep a dispensing clerk. And pray, who would *he* have for his dispensing clerk? Would he take his untutored student, probably a country patient's son, to "mix and pour" his medicines together, to be retailed to his patients? Could he have the services of an M.D. to mix his remedies? No, his first thought would be, where he could get one who is skilled both in knowledge of materia medica, chemistry, and the pharmacopœia, and a practical knowledge of operative pharmacy.

I do not believe I am far wrong when I assert that fifty per cent. of our physicians, to-day, have no more than a superficial knowledge of chemistry. It has not been required of them to know the details in the manufacture of a chemical compound.

Administration and therapeutical effect are the chief consideration of the physician. Incompatibilities, dangerous and other impurities, adulterations, etc., are the consideration of those who have made them their special study.

Perhaps the practice of Dr. Eustis does not demand the use of an extended list of pharmaceutical preparations. How many physicians are skilled in the making of suppositories? And how many are willing to occupy their time in making them? He says, "water costs the druggist nothing." Possibly that is the limit of his materia medica. According to that statement, the druggist swindles the patient by charging exorbitant prices for water; and for this one reason, in his opinion, the profession of pharmacy should be exterminated.

Such an assertion as his might be received in some places, but in most competitive pharmacy prevents all possibility of its acceptance. According to his ideas I fear the pharmacist would be condemned to become merely a retailer of patent medicines and soda-water.

Yours truly,

E. G. Seibert, Ph.G.

Paterson, N. J., Dec. 26, 1887.

Notes and Comments.

Insanity Following the Use of Anæsthetics in Operations.

Dr. George H. Savage, lecturer on Mental Diseases at Guy's Hospital, London, says (*Brit. Med. Journal*, December 3, 1887) all writers and observers have noticed that one cause alone is very rarely efficient for the production of any attack of insanity, and that usually there are several predisposing causes which may have been in operation for a long time, as well as one or more exciting causes which may have been in action for much shorter periods. To make his own opinion clear, he states the following propositions: (1) The most common form of mental disorder that comes on in such cases is of the type of acute delirious mania; (2) though such mental disorder is generally of a temporary character, it may pass into chronic weak mindedness, or it may pass into (3) progressive dementia, which cannot be distinguished from general paralysis of the insane. The author then reports cases in which alcohol; acute diseases such as scarlet fever, measles, and pneumonia; and in one case a toxic dose of belladonna, seemed to be the immediate exciting cause of an outbreak of acute insanity. All of these patients were predisposed to nervous affections. Coming to the more immediate subject of his paper, he reports several cases in which the administration of an anæsthetic seemed to him to be the immediate cause of insanity. The following is one of the cases, which was communicated to him by Dr. H. Selfe Bennett:

The patient was a young married woman, mother of one child aged ten years, at whose birth transfusion had to be performed and stimulants largely ordered. This patient used to send to the doctor from time to time for hysterical attacks. He found that these were due to alcohol. After three years of medical care she was found to have developed into a chronic drinker. She never had delirium tremens, or any other severe attacks beyond the hysteria (which, by the way, is not uncommon in such conditions). One night the doctor was sent for, to find the patient delirious, conjunctivæ insensible, urine and fæces passed involuntarily; irregular movements of all kinds were being made, and speech was incessant. It was found that she had been as usual in the morning, and had gone to the dentist to have some teeth extracted. Nitrous oxide was used for this purpose, and the outbreak followed rapidly on this. She never regained her senses or recognized her friends. She was in a state of delirious mania for three weeks, then settled into dementia, in which she remains, silly and fat. The points in this case are the acquired nervous instability, the acute delirious mania, with its consecutive dementia, following in a few hours the use of nitrous oxide.

He also refers to several cases of insanity which have followed ovariotomy; but admits that there is at present no evidence to connect insanity in these cases with the administration of an anæsthetic. He concludes his paper by remarking that one or two practical questions arise for the surgeon, one of the most important being whether neurotic inheritance or neurosis in the individual, as proved by previous attacks of insanity, should in any way affect the prognosis in operations, and to what degree it should interfere with operations of convenience not essential for the prolonging or saving of life.

The Contagium of Syphilis.

Dr. J. Disse has been investigating the blood of syphilitic patients, as a result of which he finds, after staining by Gram's method, numerous cocci which are free and active in the blood plasma. These cocci he has cultivated, and states that he has seen the diplococci, which are the active form, produced from them. He has demonstrated the presence of these organisms in twelve cases of syphilis, in ten of which the disease was latent, while in two an eruption existed; on the contrary, he never found these cocci in the blood of non-syphilitic patients, though he often investigated it. Moreover, the same form of coccus was found in Japanese, and in Europeans, no matter whether they acquired syphilis in Japan or Europe, and no matter at what time or place they were examined for the cocci.

If a small quantity of a pure culture is introduced into the blood of animals, the cocci multiply, and can be demonstrated after a long time. Inoculation also produced characteristic lesions, which in turn contained the cocci.

The author gives a detailed account of the post-mortem examination of the organs of animals which had been inoculated with cultures of these cocci, which account will be found in the *Deutsche med. Wochenschr.*, October 13, 1887.

It will, perhaps, be remembered that Lustgarten, who investigated this subject before Disse, found a bacillus which he believed to be characteristic of syphilis. Others, including Disse, do not think that this bacillu is in any way distinguishable from the ba

cillus of præputial secretions, smegma, etc. More recently Doutrelepont, of Bonn, has stated (*Lancet*, October 15, 1887) that he believes the streptococci have no relation to the syphilitic process in hereditary syphilis, but that their presence is due to a septic infection, which the cutaneous and mucous lesions of syphilis render possible.

Improved Caustic Paste.

Dr. Jules Felix, of Brussels, employs the following:

℞	Powdered starch	37 parts.
	Wheat flour	112 "
	Bichloride of mercury	1 "
	Chloride of zinc	110 "
	Iodol	10 "
	Croton chloral	10 "
	Bromide of camphor	10 "
	Crystallized carbolic acid	10 "

Pulverize the ingredients separately, mix in a glass mortar, and add water to produce a paste.

The preparation produces little pain, its action is under perfect control, being proportioned to the duration of the application; it is antiseptic and hemostatic, and produces eschars hard and well limited, which separate spontaneously in a few days.—*Phar. Era*, November, 1887.

The Mechanism of Cyanosis.

At a meeting of the Æsculapian Society of London (*Lancet*, December 3, 1887), Dr. Alexander Morrison read a paper on the mechanism of cyanosis, which included a synopsis of seventy-five collected cases of cardiac malformation. This paper was the sequel of one read before the Society on February 18, 1887, on the case of a child, seven years old, in whom fatal cyanosis was found on *post mortem* examination to have been associated with the following physicial conditions: The ductus arteriosus was closed, the pulmonary artery narrowed to an eighth of an inch, the septum of the ventricles imperfect at its base, the aorta arising at this point from both ventricles. Cyanosis was present from birth, and had become most marked during the last two years. It was attended with severe attacks of dyspnœa. Dr. Morrison regarded the state of the ductus arteriosus in relation to the pulmonary artery as most important. The former channel was open in forty-six of his collected cases, closed in eighteen, and doubtful in the rest. He found that in the first group cyanosis appeared earlier, and the duration of life was shorter than in the second. As regards the mechanism of cyanosis, he considered the chief, though not the only agency at work, to be a diminution of the aspiration exercised by the lungs.

NEWS.

—Dr. Morell Mackenzie returned to London from San Remo, Dec. 30, 1887. He is inclined to take an optimist view of the case of the German Crown Prince.

—Dr. Joseph Leidy has been re-elected President of the Academy of Natural Sciences. The additions last year to the library of the institution numbered 3380 volumes.

—Surgeon-General Hamilton, or Surgeon Stoner of the Marine Hospital Service, will shortly be sent to Peru as a delegate to the Sanitary Conference to be held at Lima.

—An infant, eight months old, has had its leg amputated above the knee in a New York hospital. The child suffered from sarcoma, that appeared below the knee four months after the sufferer's birth.

—Application was made, Dec. 15, 1887, for a charter for the Gynecean Hospital in Philadelphia, the object of the corporation being "to maintain a hospital for the treatment of diseases peculiar to women."

—It is reported that a boy eleven years old went to the New York Dispensary, December 19, to have a molar tooth extracted. After its removal a profuse hemorrhage ensued, and proved fatal in twenty minutes.

—Dr. H. W. Stelwagon delivered a lecture in the course before the Nurses' Training School, at the Hospital of the University of Pennsylvania, Dec. 15, 1887, on the "Hygiene and Care of the Skin in Various Illnesses."

—The low price at which big sales of cocaine have been made in St. Louis of late aroused suspicion among the local druggists. An analysis was made, and the cocaine found to be very greatly adulterated with pulverized borax.

—The matter of international copyright came up in the U. S. Senate, December 19, on the presentation by Senator Hale of a petition for the passage of a proper copyright law, to which were attached the names of Dr. Oliver Wendell Holmes, John G. Whittier, Charles Dudley Warner, Louise Alcott, S. L. Clemens, Bret Harte and others.

—The Board of Trade of the city of Chester, Pa., protests against the continuance of the quarantine station of the port of Philadelphia, in its present location at Tinicum, which is within four miles of the city of Chester, with a surrounding population of 40,000 people; and earnestly recommends the establishment of a national system of quarantine, and the removal of the station complained of at the earliest practicable time.

—The *Chicago Tribune*, Dec. 14, 1887, states that the medical staff of the Cook County Hospital is to be reorganized. On Dec. 13, the commissioners who govern the hospital adopted resolutions requesting the resignation of the present staff, and providing that, after Jan. 1, 1888, the staff of the Hospital shall consist of twenty-one members: viz., eight surgeons, eight medical men, three gynecologists, one oculist, and one pathologist. The staff is to be made up of two members from Rush Medical College, two from the Chicago Medical College, two from the College of Physicians and Surgeons, one from the Woman's Medical College, and fourteen from the Medical Association of the City of Chicago.

—Professor Edgar Crookshank, of the Bacteriological Laboratory, King's College, London, England, has been investigating the disease in cows which Klein has declared to be capable of giving scarlet fever to man, through the medium of their milk. Prof. Crookshank believes that he has discovered this disease to be true Jennerian cow-pox. Cultures made from the discharge of the ulcers upon the cows' teats resembled those of the *micrococcus scarlatinæ* described early in 1887 by Klein so closely as to be apparently identical with them.

A young man who caught the disease from a cow, was seen by Prof. Crookshank when the disease was in its early stage. He presented an umbilicated pock. This pock developed in a most typical manner, and lymph taken from the vesicle produced typical vaccinia in calves.

—The "Sloane Maternity Hospital" and the "Vanderbilt Clinic," Tenth avenue and Fifty-ninth street, New York, were formally dedicated Dec. 29, 1887. The exercises, including an address by Professor T. Gaillard Thomas, M.D., took place in the lecture room of the College of Physicians and Surgeons, which adjoins the new institutions. The Maternity Hospital stands upon a part of the land given by the late William H. Vanderbilt to the College. Mrs. Sloane has endowed all the beds in the institution, so that they will be free perpetually. All the pupils in the New York Hospital Training School for Nurses, in Sixteenth street, will have to serve in the Maternity Hospital before graduation. The Vanderbilt clinic is connected by a covered way with the College of Physicians and Surgeons. It also contains an amphitheatre for demonstrations and a number of private operating rooms.

HUMOR.

A PROMINENT PHYSICIAN has a card hanging in his office, reading: "Consultations from 1 to 2. The other day, a millionaire patient handed him a dollar and a half, and got out before the doctor noticed that some vandal had placed the sign of $ before the figures.

HEROIC TREATMENT.—"Colonel," said a Kentucky lady to her sick husband, "the doctor says the ice water you are taking is doing you so much good that he thinks he will further increase the dose."

"But, my dear," expostulated the sick colonel, "does he understand that it has already been increased to a teaspoonful three times a day?"

HOTEL WAITER—You are late for lunch, sir.

Eminent Physician—Yes, I had to finish my magazine article on "The Laws of Health," so as to get it into the next mail. What have you to-day?

"Hot rolls, clams, plum pudding, apple dumplings, mince pie and fruit cake,"

"Bring 'em all."

ANXIOUS ARKANSAW MOTHER—"Tommy, is that a green persimmon you air eating?" "Yes, maw." "Don't you know it ain't healthy to eat green persimmons on an empty stomach?" "I ain't eatin' this green persimmon on an empty stomach. I ate a peck of 'em before I tackled this one."

A GENTLEMAN of Buffalo said not long ago to his physician, a doctor who has perhaps the largest and most lucrative practice of his profession in Buffalo: "It was a bad day, doctor, when you persuaded me to leave off drinking four years ago." "How so?" said the doctor, "you never looked as well in your life." "Very true!" responded the gentleman, "but my doctor's bill in the mean time has not been $10."

OBITUARY.

DR. FERDINAND VANDEVEER HAYDEN.

Dr. Ferdinand Vandeveer Hayden, the well-known geologist and explorer, died at an early hour at his residence in Philadelphia, December 22, 1887, after a long illness. He had been for over a year a sufferer with locomotor ataxia, which was the immediate cause of his death.

Dr. Hayden was born in Westfield, Mass., on September 7, 1829. He early settled in Ohio, and entered Oberlin College, from

which he was graduated in 1850. He then studied medicine, receiving his degree three years later at the Albany Medical College. He engaged in geological work and soon distinguished himself in explorations in the far west. In May, 1859, he was naturalist and surgeon to the expedition for the exploration of the Missouri and Yellowstone rivers under Capt. Wm. F. Raynolds. He continued in this service until May, 1862, when he joined the army as assistant surgeon of volunteers, being assigned to duty in the Satterlee Hospital, in this city. On February 19, 1863, he became full surgeon, and was sent to Beaufort, South Carolina, as chief medical officer. He was appointed Assistant Medical Inspector of the Department in Washington, in February, 1864, and in September of the same year was sent to Winchester, Va., as Chief Medical Officer of the Army of the Shenandoah. He resigned May, 1865, when he was breveted Lieutenant-Colonel. In the fall of the same year he became Professor of Geology and Minerology in the University of Pennsylvania, which chair he held until 1872, when his duties in connection with the United States Geological Survey necessitated his resignation.

It was due largely to his influence that Congress set apart the Yellowstone National Park as a perpetual reservation. In 1873 the bureau became the "Geological and Geographical Survey," Dr. Hayden continuing in charge until 1879, when the then existing national surveys were consolidated into the "Geological Survey." He was a member of various scientific societies in this country and abroad, being elected in 1873 to the National Academy of Sciences. The University of Pennsylvania conferred on him the honorary degree of LL.D. during the present year. His writings included a large number of government reports, besides numerous scientific papers, and a series of "miscellaneous publications" on special subjects written by authorities in the specialties on which they treat.

W. G. OUCHTERLONY, M.D.

On the 10th of November, 1887, Dr. Wm. G. Ouchterlony died suddenly. He was educated in the schools of Louisville and at the University of Michigan. He took the degree of M.D. at the University of Louisville in March, 1886, and went abroad a few weeks later. He returned home late in the season last year, and went at once into practice in his father's office. He enjoyed the confidence and esteem of a wide circle in Louisville.

DR. MIDDLETON GOLDSMITH.

Doctor Middleton Goldsmith, once a prominent citizen of Louisville, a professor in the Kentucky School of Medicine, and during the war a leading surgeon, having been at one time on the staff of General Grant, died on the 26th ultimo, at Rutland, Vermont, to which place he removed from Louisville soon after the war. Dr. Goldsmith inaugurated the pavilion hospital service during the war, and gained a large share of credit by the introduction of the use of bromine in the treatment of hospital gangrene.

DR. A. B. PALMER.

Dr. A. B. Palmer, Dean of the Department of Medicine and Surgery, and Professor of Pathology and the Practice of Medicine in the University of Michigan, died in Ann Arbor, Friday night, Dec. 23, aged 72 years.

Official List of Changes in the Stations and Duties of Officers serving in the Medical Department, U. S. Army, from Dec. 25, 1887, to Dec. 31, 1887:

Colonel J. H. Baxter, Chief Medical Purveyor, ordered to inspect the Medical Purveying Depot at St. Louis, Mo. S. O. 296, A. G. O., Dec. 23, 1887.

First Lieutenant Wm. B. Banister, Assistant Surgeon, ordered to proceed to Fort Lowell, Ariz., and report to commanding officer for duty, upon the arrival of Surgeon P. J. A. Cleary at Fort Wingate, N. M. S. O. 135, Dept. Ariz., Dec. 20, 1887.

Changes in the Medical Corps of the Navy, during the week ending Dec. 31, 1887:

Passed Assistant Surgeon C. Biddle, detached from the Marine Rendezvous, Philadelphia, and placed on waiting orders.

Medical Director C. J. Cleborne, detached as member of Medical Examining Board, Dec. 31, and ordered to Norfolk Naval Hospital, Jan. 5, 1888.

Medical Inspector M. Bradley, detached from Naval Hospital, Norfolk, Jan. 5, 1888, and placed on waiting orders.

Medical Inspector J. H. Clark, detached from special duty at Portsmouth, N. H., and ordered as member of Examining Board at Washington.

U. S. Marine Hospital Service:

The Supervising Surgeon-General, U. S. M. H. S., announces that hereafter applications for leave of absence by medical officers and hospital stewards will not be considered while such officers or stewards are under orders to change stations.

Official List of Changes of Stations and Duties of Medical Officers of the U. S. Marine Hospital Service, for the two weeks ended Dec. 31, 1887:

A. D. Bevan, Passed Assistant Surgeon, resignation accepted, to take effect January 31, 1888, and leave of absence extended to that date. Dec. 31, 1887.

W. D. Bratton, Assistant Surgeon, granted leave of absence for thirty days. Dec. 30, 1887.

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Clinical Lecture.

ACUTE PNEUMONIA—TUBERCULOSIS.*

BY NATHAN S. DAVIS, M.D., LL.D.,

PROFESSOR OF THE THEORY AND PRACTICE OF MEDICINE AND OF CLINICAL MEDICINE IN THE CHICAGO MEDICAL COLLEGE.

(Reported by William Whitford, M.D.)

Pneumonia.

Gentlemen:—Last Friday morning, among other cases, I directed your attention to a young man who came in the night before. I had not seen him enough to make a critical examination of his case. He was reported to have been seriously sick before he came to the hospital, and at the time of admission he had all the symptoms of an active grade of malarial fever. His temperature was high; his skin more or less dry, and of a sallow hue, such as is more frequently seen in malarious fevers. His pulse, though soft and lacking force, was quick and of fairly good volume; his mind was wandering. Every now and then he would drop into a drowsy condition, then suddenly awake with spasmodic force and excitement. He was very tall, but not proportionately developed; and the only history we could obtain from him was that he had been engaged with a Wild West Show which had been traveling for some months through Northern Indiana and other sections of the country up to the time he was taken sick. Examining his chest a minute or so before the commencement of our usual Friday morning remarks, and getting from him this short history, I was led to think for a moment that he was probably suffering a severe attack of typho-malarial fever. He had been exposed to malarious influences, had led an irregular life, subject more or less to excitement, variations, ups and downs, in his daily avocation. In going over his chest I failed to detect any evidences of structural or organic disease of the heart. His bowels had a tendency to looseness, requiring one or two doses of turpentine emulsion to restrain them. The character of his pulse, the discharges from his bowels, the rapid breathing, together with the excited, spasmodic arousing from a lethargic condition, led me to infer also that he might have had an inflammatory condition of the membranes of the brain in connection with his febrile condition. But while I was addressing you we heard him cough, and he brought up some characteristic pneumonic expectoration, which immediately led to a more extended examination of his chest; and it was found he had pneumonia involving nearly the whole right lung, with considerable dulness. The sound that was heard belonged to the second stage of the disease; it was not a crepitant râle, but a coarse, mucous rhonchus, with dulness throughout the right side of the chest, and to some extent on the left. The patient was put upon the muriate of ammonia mixture, and a fair, but not extravagant use of quinine, relying upon the muriate of ammonia as an expectorant, and the quinine for its known efficacy in certain grades of pneumonia to help to sustain the tone of the pulmonary vessels and to lessen the amount of exudation and extravasation going on. After having swathed his chest with poultices, it required two or three persons to keep him in bed; he struggled and fought most of the time. In addition to the other remedies we directed carbonate of ammonia; and here we experienced the same trouble as in the application of the poultices. His mental wandering, excitement, and pug-

*Delivered at the bedside in the Mercy Hospital, Chicago, Illinois.

nacious disposition to resist everything given him, rendered it exceedingly difficult to administer medicine or nourishment regularly. The patient died in about forty-eight hours from the time of admission, as I had supposed he would at the time I first saw him.

A *post mortem* examination was made. It was found that nearly the entire right lung was in a complete state of hepatization; a considerable portion of the lower and posterior part of the left was in a similar condition. The upper and anterior portion of the left lung—the part where I put my ear to listen to the cardiac sounds to see whether or not I could detect any structural or organic diseases of the heart—was the only portion of his lungs that remained and was capable of carrying on respiration. There was no disease found effecting the heart. The liver was considerably enlarged, doubtless from the secretion, much the same as it is apt to be found in connection with protracted remittent and malarious fevers, with some fatty degeneration. The spleen, however, was not much enlarged—a feature of interest, inasmuch as it tends to partly overthrow the idea of the existence of typhoid. In following out the examination, there was an intense inflammatory congestion in the coats of the intestines along the lower part of the ileum and junction with the colon. The inflammatory engorgement of the intestines was sufficient to account for the diarrhœal discharges he had, and in laying them open no characteristic enlargement of Peyer's patches could be found; in fact, the usual accompaniment of typhoid did not exist either in the glands of the interior of the intestines, the mesentery or spleen; but there was simply an inflammation of a portion of the intestines together with the conditions we have already pointed out. Almost all portions of the kidneys were studded with hydatid cysts, varying in size, and filled with a yellow serous fluid which bore a close resemblance to urine. There were also some cicatrices on the surface of the kidneys, giving the appearance as though there might have been cysts near the surface, which at some time or other had broken and finally collapsed. The number of cysts pervading both kidneys was quite unusual. The *post mortem* examination in this case revealed a condition of considerable interest to us, taken in connection with the pneumonia, the persistent mental delirium, the general run of fever, and the fatal result. It is undoubtedly true that the patient had contracted strong malarious influences, disposing to the development of fever; and the febrile condition supervening, with its effects upon the general secretory action, rendered the kidneys incapable of carrying on the requisite amount of elimination. The pneumonia probably commenced during the second week of the progress of the attack, and a day or so before he came to the hospital. The improper and inadequate elimination of urea doubtless left elements in his blood which kept up the cerebral excitement to which we have previously alluded—a condition which at any time during the last few days of his life might have brought on uræmic convulsions, followed by coma and death.

Tuberculosis.

This patient's trouble came on about four years ago: at that time he was attacked with hemorrhage, or spitting of blood. The expectoration he raised then, we are informed, was not mixed with mucus; it was a pure, characteristic hemorrhage, such as we see in cases of hæmoptysis or coughing of blood from the lungs. Whatever cough he had at that time passed away in a measure, although he tells us he had more or less of a mild cough all last summer. As we look at him, we observe his general nutrition is below par; he looks weak, pale and emaciated. About a week ago he was attacked with hemorrhage, and brought up, as near as can be ascertained, a half pint of blood; and since that time he has had a continued harassing cough.

He feels pain in the left side of his chest, and, when he coughs, the phlegm he raises is tinged or slightly streaked with blood. When I commenced to examine him, I found his chest enveloped closely with wet cloths, so on that account I did not feel disposed to expose him and subject him to a thorough and protracted examination; perhaps I should have done so. However, I went over his chest enough to convince me that there was something else back of the hemorrhage. You will notice a flattening beneath the clavicle, and that neither side of his chest is filled out. The respiratory sounds are prolonged, exaggerated, and rough on both sides, but a little more so on the left; there is an increased fremitus of voice heard during physical exploration. The history of the case, the characteristic flattening in the infra-clavicular region, and the strong fremitus of voice on this (the left) side—not cavernous, but a strong bronchophony—leaves the way perfectly clear for the inference that this man has got a regular case of slow tuberculosis, the miliary tubercular deposit having commenced there, in all probability, four or five years ago, gradually increasing and invading the lungs little by lit-

tle, tending, during the progress of the disease, to block some of the vessels, giving rise to the hemorrhage to which he referred.

During the progress of the second stage of tuberculosis, the miliary tubercular deposits are undergoing a process of softening, and the surrounding lung tissue is more or less filled by a low grade of pneumonic engorgement, and sometimes a sub-mucous râle may be developed, which is not removed temporarily by the act of coughing, but is developed regularly near the end of each moderate attempt at inspiration, indicating that it depends upon the ingress of air into textures which are more or less filled with a glutinous or viscid fluid. By and by, as the tubercular process continues, the area of congestion in the vessels becomes greater. The mere loss of a half pint of blood amounts to very little; the patient can make up that in a week with a fair appetite and digestion. But it is nevertheless important inasmuch as it points indubitably to obstruction in the pulmonary tissue, and that obstruction, added to the other symptoms, shows very clearly that it is due to a tubercular deposit—a deposit that has not as yet undergone the process of softening; consequently if this patient could go to a milder, more congenial climate, his chances for ultimate recovery would be far greater than they are at present. I have no doubt the miliary tubercular deposit is in a crude state at present, and while there may have been little or no extravasation into the pulmonary tissues, there is danger that it will degenerate and set up a regular suppurative process in about three, four, or six weeks, and while he may not feel sick, be able to dress himself and perhaps walk about the wards some, yet he will continue to cough and expectorate considerable purulent matter, and on the whole getting weaker and more emaciated, and in about six weeks more we will begin to get a cavernous sound at some point of the upper part of the involved (left) lung—in other words, our patient will be in a condition favorable for the commencement of the second stage of tuberculosus disease. By the second stage I mean the stage of softening, disintegration or degeneration of the tubercular masses and the establishment of regular suppurative processes, causing more cough, a quickening of the pulse, probably hectic fever, more night sweats, and soreness in the chest at certain times. When the suppurative process of the disease has about completed itself, the third stage may be said to commence; and during that stage we would probably have an excavation of one or more tuberculous cavities, and a characteristic hectic fever.

In the first stage the miliary tubercular deposit or deposits, as the case may be, are in a crude, unchanged condition; they may exist in a latent state for years — indeed many cases go on for several years without passing beyond that stage. Inspection at this time will usually show a noticeable degree of flattening in the infra-clavicular region, or, as I have informed you on previous occasions, a lessening of the antero-posterior diameter of the upper part of the chest. In case the tubercular deposit is present, or exists only in one lung, the difference between the affected side and that of the other is well marked. If you carefully percuss the chest, so as to get the tone of sound clearly and unmistakably, you will detect a perceptible diminution in the resonance of the affected side, in the infra-clavicular space. In the first stage the physical signs are not merely a production of new sounds, but simply an alteration of the natural respiratory murmur, increased fremitus of voice and diminished resonance on percussion.

The existence of tuberculosis is not always proven by the physical signs alone; they simply prove the existence of something which diminishes the amount of air in the lung, which we examine, and thus renders its structure more dense.

Auscultation in the second stage gives alterations in the respiratory murmur. We notice an irregularity in the development of the inspiratory sound, or its renewal in expiration, and usually there are added more or less mucus râles. The râles at first will be moveable, brought about by mucus accumulations in the bronchial tubes and the passage of air to and fro through it.

The treatment for such a patient as this is first, a change of climate, where he can breathe soft, mild, genial, invigorating air, with good hygienic surroundings, instead of being exposed to a rough, harsh, cold, damp climate, with gaseous, noxious vapors, frozen ground, snow, etc., such as we get in Chicago—a climate where the air is bracing and soothing instead of irritating to the air passages. Were such patients to take up their residence in a good, favorable climate, the disease would not, in a great many instances, extend beyond the first stage, and they would live and enjoy life to a reasonable old age, and attend to business all the while. While in some instances medication will fail, in others it will do good. Medicine is exceedingly useful during the inflammatory attacks; you can fight the disease oftentimes so as to curtail the inflammatory process for a

good while, even without the patient going to another climate. This is partly the reason why many individuals are so reluctant to get into a more favorable country, where the air is bracing, wholesome and soothing. A very large majority of such patients do not comprehend the importance and danger of the situation; they may tell you they do not feel very sick, and on that account it is hard for them to believe that there is anything serious taking place until the second stage is ushered in and fully established, then they begin to have decided night sweats, associated with a rapid loss of flesh, shortness of breath, and commence to think their disease is assuming a serious aspect. The great object in all such cases is to study the initial or primary stage of this tubercular form of disease. I verily believe that this patient commenced to have these miliary tubercular formations or deposits four or five years ago.

Further treatment would consist in giving him such anodyne expectorants as will efficiently allay the irritation, lessen the temporary congestion or inflammatory action as well as possible, for semi-pneumonic processes have undoubtedly been set up around the point where the hemorrhage originated. We put him upon the muriate of ammonia mixture, once every four hours, together with the carbolic acid and iodine mixture alternately every six hours. As an alterative for aiding the muriate of ammonia, counteracting the deteriorative changes in the lungs, lessening further tendency to hemorrhages, I suggest that he be given a pill (three grains of ergotine) twice a day, one after breakfast, and one about eight o'clock in the evening.

[In combating the inflammatory attacks, lessening the cough, rendering the expectoration easy, promoting rest at night, and yet producing very little impairment of appetite or digestion, Dr. Davis recommends also a combination of the muriate of ammonia, tartrate of antimonium and potassium, and sulphate of morphia, dissolved in the syrup of liquorice in such proportions that four cubic centimeters or one teaspoonful would contain four decigrams (gr. vi) of the first, 4 milligrams (gr. $\frac{1}{16}$) of the second, and 5 milligrams (gr. $\frac{1}{12}$) of the third, to be taken every four or six hours, according to the severity of the symptoms.]

—There is a hospital for women at Tashkend, in Turkestan, established by some Russian ladies. It was started some years ago, and the native female population take advantage of it in increasing numbers.

Communications.

THE TECHNIQUE OF OOPHORECTOMY.*

BY CHARLES MEIGS WILSON, M.D.,
PHILADELPHIA.

Although so much has been written on the subject of oöphorectomy that it seems hardly possible to add anything new to our present knowledge on the subject, yet success depends so much on the manner and the details of operating, that it is not perhaps a waste of time to call attention to those methods which have received the stamp of approval of the surgeons who have thus far had the best results in abdominal surgery. The methods detailed below are the *common* property of the medical profession, evolved by the experience of many operators. Some the author first saw used in England and in Germany, others are the result of American ingenuity, and all are of great importance in the production of good results after operating. If to any one man belongs a larger share of credit than to the rest in popularizing these methods in this section of the country, certainly Dr. Howard A. Kelly, of Philadelphia, deserves it.

Preparation of the Patient.—Let us first consider the preparation of the patient. In all cases it is advisable for the operator to have his patient under observation some little time before the operation. This has the double advantage of giving the operator and the patient time to become acquainted with each other, and for the patient to acquire confidence in the operator, and gives the surgeon opportunity to study carefully the case. Too much condemnation cannot be given to hasty and ill-considered operations. The urine should be carefully examined, in order to see that it is free from albumin. Neglect of this rule has doubtless oftentimes been the cause of the patient's death. The gastro-intestinal canal should be in state of healthy function, and the day preceding the operation all portions of the intestine should be thoroughly emptied. This is best secured by the administration of some gentle laxative, such as the compound liquorice powder, in one or two drachm doses; or, if there be some torpidity of the liver, by the administration of one-twelfth of a grain of calomel every hour until the bowels are opened; care, however, being

*Read before the Philadelphia County Medical Society, December 28, 1887.

taken in both cases not to purge the patient, and not to set up any excessive peristalsis. On the morning of the operation, the rectum should be emptied by an enema, and in order to prevent the accumulation of gas in the intestines, and to avoid gaseous distention of the intestines, it is generally best to put into the laxative enema administered a a little turpentine emulsified with the white of an egg. This, as a rule, relieves the intestines of any accumulation of gas present in them, and at the same time is not irritating.

The patient should have, on the morning of the operation, a hot bath, which will add to her comfort and remove any sebaceous matter on her abdomen; it is best to have the patient sponged with alcohol after the bath. Also, on the morning of the operation, the patient should abstain from taking any food, unless it be a cup of strong coffee or a little milk and lime-water. The administration of this food should always precede the time of operation by three or four hours. Above all, it is necessary that the patient have a chance to recuperate her strength and prepare for the mental and physical ordeal of the operation by having a rest in bed of at least three days before the operation, and this is especially important if the patient has come on a long journey and is fatigued with traveling.

The Surroundings of the Patient.—By election, it is always best to operate upon the patient in a hospital, particularly if one have a hospital ward especially devoted to this class of work, in preference to operating upon the patient at her own home. The reasons for this are obvious. In the hospital there are trained assistants and trained nurses, and if the operator be busy with this kind of work, the nurses have no other cases to manage, and are especially trained and especially adapted to this work. Again, too, in the hospital the operator always has his own assistants, who are accustomed to his methods, who understand his wants, and who know exactly what to do at the right moment. In the hospital the operator, as a rule, has an assistant whose especial duty it is to administer the anæsthetic, and where there is an anæsthetizer properly trained for his work and competent, the operator's mind is entirely relieved of the responsibility of the administration of the anæsthetic. He does not have to look at the patient to see how she is doing under the influence of the anæsthetic; he does not have to be interrupted in his work by the patient getting too much ether or chloroform, nor is he bothered with rigidity and stiffening of the abdominal parietes because the patient is not sufficiently under the influence of the anæsthetic.

At the patient's home, especially if it be far distant from the home of the operator, it is not always possible to have either good nurses or good assistants, and the lack of these contributes largely to the difference in the mortality rate in operations done at the patient's home and those done in hospitals especially adapted to this work. Again, in the hospital the operator has time to investigate thoroughly the patient's case, and to weigh all the points *pro* and *con*, whereas at the patient's home he is often obliged to operate hastily, and with a diagnosis formed after a hasty inspection of the patient and study of her case, which is oftentimes not confirmatory of the diagnosis of the regular medical attendant. Prior to the operation, it is better that the patient should have a room remote from the operating-room, with all its appalling armamentarium and paraphernalia, in order that she may not become frightened or worried by seeing the preparations for the operation. It is best on the morning of the operation to bring the patient to a room adjacent to the operating-room, where she may rest until the anæsthetic is administered. The room should be bright, cheerful, airy, and spacious, and should have pictures on the walls, or something in the room to divert the patient's attention. The patient should also be constantly attended by a nurse during the hours preceding the operation, in order that she may not become lonely and allow her mind to dwell upon the operation. It is best, both before and after the operation, to exclude rigorously the friends and relatives from access to the patient, and to have the patient give herself up entirely to the operator, in order that he may control her movements without the interference of relatives or friends.

The Operation.—The room for the operation should, when possible, have walls and floors which can be thoroughly cleaned and disinfected, in order that the operation may be conducted in an aseptic atmosphere. For this purpose, the author's own operating-room has tile floors and glazed tile walls, so that the whole place can be flooded out with water, and placed in a thoroughly clean condition. An operating-table of plain wood, painted, resembling in size and shape the ordinary kitchen table, is all that is really necessary. One or two stands of light construction, and upon large castors, in order that they may be readily wheeled from one portion of the room to another, and a chair

for the assistant who holds the patient's limbs, are all the furniture required. A large can containing distilled water, and an alcohol lamp or gas burner under it, so as to maintain the heat of the water at a fixed temperature, and a tube running from the can to the table, so that at any time during the operation the whole operative field can be flooded, is also in the room. The sponges are used over and over again, until the sponge fibre commences to show evidences of disintegration. These are always of the finest quality, and for the most part those which are known as potter's sponges, or thin, flat sponges. For the first time, they are prepared as follows:

All of the dust is first beaten out of them. They are then immersed in a fifteen per cent. solution of hydrochloric acid for forty-eight hours. They are next thoroughly washed until all the acid is removed from their interstices. Then they are placed for half an hour in a solution of permanganate of potassium, 180 grains to five pints of water. This is done in order to bleach them. The hydrochloric acid solution is, of course, for the purpose of removing any mineral matter that may be in their meshes. They are again washed in running water, and placed in a solution consisting of ten ounces of the hyposulphite of sodium, five ounces of hydrochloric acid, and sixty-eight ounces of water. They are allowed to remain in this solution for a period of from two to four hours, until thoroughly bleached. They are next thrown into troughs of running water, where they are allowed to remain for several hours. Afterward they are placed in jars containing solution of bichloride of mercury (1–1000), and hermetically sealed until the time of operation. After an operation, they are washed out in warm water, then soaked in a solution of sodium carbonate, half ounce to a pint of water, for three or four hours, then rewashed in warm water and put back in the 1–1000 bichloride solution, ready for use again. The instruments are all nickel-plated, with the exception of the cutting edges. They are prepared by being first scrubbed with glycerine soap, and then immersed for several minutes in boiling hot water. They are then laid upon towels which have previously been immersed in the solution of the bichloride of mercury (1–1000), and thoroughly dried by superheated steam. They are then ready for use. The needles are kept in a five per cent. solution of carbolized oil. The ligatures and sutures are kept immersed in a solution of bichloride of mercury (1–500); they are always washed in distilled water immediately before being used. For suturing the abdominal wall, silkworm-gut has been found most satisfactory, clamped and held in position by perforated shot. For ligatures, the twisted Chinese silk has been found to be the best. For anæsthesia, chloroform has been used instead of ether, unless the operation is likely to prove a long one. The reason that chloroform is preferred to ether is the author's belief that chloroform, when properly and carefully administered, is nearly as safe as ether, and because with chloroform, as a rule, there is none of the bronchorrhœa and gastric disturbance which usually follow the administration of ether. Where ether is given, it is found that a less amount is required, and that the anæsthesia is more satisfactorily induced and maintained by administering the ether upon the Allis inhaler rather than with the ordinary cone. Where chloroform is employed, it is usually administered by means of the shield devised by Professor Billroth and used in his clinic.

The temperature of the operating-room should be about 75°. It is best to cover all portions of the patient's body with light blankets, with the exception of that portion of the abdomen involved in the seat of operation. An assistant sits at the foot of the operating-table, and receives and holds the patient's limbs, passes the catheter just before the operation, and, when necessary, with the finger in the vagina, lifts ovary, tube, or pedicle up into the abdominal wound, as the operator may desire. A trusted assistant takes charge of the anæsthetic, and does nothing else. The chief assistant stands on the left side of the patient, ready to give immediate aid to the operator.

Immediately preceding the operation, the patient's abdomen is wiped off with a little ether, in order to remove any greasy matter that may be present upon the abdominal wall, and it is then washed with the bichloride solution (1–1000), and carefully dried, especial care being taken to see that all the little folds about the umbilicus are perfectly clean. If there be an abundance of suprapubic hair, sufficient is removed to give a chance for extending the incision downward if necessary. The operator having satisfied himself that the patient is sufficiently anæsthetized—and by sufficient is meant that she is anæsthetized to the surgical degree—the abdomen is opened with a few rapid strokes of the knife, without the use of the director.

The operator can readily judge of the depth of the abdominal wall, and really no care is required until the subperitoneal fat is reached. The abdomen is opened in the median line,

care being taken to strike the linea alba, if possible, so as not to open the sheath of the recti muscles. If we fail to strike the linea alba, no time is lost in dissection in order to reach it; but if we miss it, the abdomen is opened, if need be, through the rectus muscle. The rule with reference to the incision best to be followed is to make it as small as compatible with the removal of the ovary or of the growth. Where oöphorectomy is performed, an incision one and one-half or two inches in length is amply sufficient. On the contrary, where an ovarian cystoma is to be removed, and the tumor is a large one, or, perchance, semi-solid, or where the adhesions are numerous, it is a great deal better to enlarge the incision in order that the growth can be readily gotten at, rather than to attempt its removal without knowing exactly what we are doing, and without having room enough to raise it up through the abdominal wound. No care is taken to prevent the blood from the wound in the abdominal wall escaping into the peritoneal cavity, and although it is always best to avoid allowing the contents of a cyst getting into the abdominal cavity, it is thought best to complete the operation rapidly, rather than to avoid the escape of the cyst contents into the abdominal cavity. If, however, we are dealing with a pus tube, then, of course, the greatest care must be used to avoid the escape of the pus into the peritoneal cavity, owing to rupture of the tube wall. The pedicle is transfixed with an aneurism needle, the penetrating arm of which is at right angles to the handle, and tied with stout, twisted Chinese silk. The loop of the ligature carried through the pedicle is held as the needle is withdrawn, and divided; each half of the pedicle is tied, and then the whole pedicle is tied with the remaining parts of one of the ligatures. The pedicle is severed close to the ligature, care being taken, however, to leave sufficient of the pedicle to prevent the ligature from slipping. An important precaution to take, to avoid secondary hemorrhage, is to hold the pedicle with the Martin forceps for a few moments and then, if there be no evidence of hemorrhage, it is dropped back into the peritoneal cavity. Where there is any tendency to hemorrhage from the pedicle, it is lightly touched with the flat button of the Paquelin cautery. Where the ovary is bound down by adhesions, and there is oozing from those which have been torn asunder, they are lightly touched with the finger, which has been rubbed against a piece of the perchloride of iron. The abdominal cavity is then invariably flooded for about five minutes with a stream of distilled water at a temperature of 100° F. It is surprising to see how, when a patient is profoundly shocked, this intra-peritoneal irrigation with hot water will immediately restore the equilibrium of the pulse and rally the patient from the shock. In operating, care should always be taken not to handle the ovary or the meso-salpinx any more than is absolutely necessary, because, as has been frequently noted, the patient's respiration becomes embarrassed, and oftentimes temporarily ceases during the time that the ovary is in the grasp of the operator's fingers. Where there is a cyst of any size, its contents are aspirated with Mears's trocar; but where the cyst is small, we prefer to enlarge the abdominal wound, rather than to delay the operation by evacuating the contents of the cyst with the aspirator.

The Toilet of the Peritoneum.—First, as noted above, the peritoneal cavity is thoroughly irrigated with distilled water at a temperature of 100° F. The patient is then turned on her side and all the water allowed to drain out that will. She is then again turned upon the back and the peritoneal cavity carefully sponged, the intestines and mesentery being held out of the way with one hand, while with the other the operator carries the sponge attached to a bayoneted sponge-holder, first into the retro-vaginal portion of the peritoneal cavity and then into both iliac fossæ. The sponging is continued until all shreds of coagulated blood are removed, and, until when the sponge is brought up, only a pale pinkish fluid escapes when the sponge is squeezed.

When we are sure that all hemorrhage has ceased within the peritoneal cavity, the intestines, if any have been left out of the abdominal cavity, are carefully replaced and the mesentery is folded over them. If it be necessary to lift loops of intestines out of the abdominal cavity, they should be carefully wrapped in soft towels kept moist and at a temperature of 100° F. Upon the mesentery is placed a thin, flat potter's sponge which extends half an inch or more around all portions of the wound. This is placed there in order to absorb any blood which may escape from the needle punctures. Its centre is grasped by a hæmostatic forceps in order to facilitate its removal after the sutures have all been introduced. A strong, stout needle threaded with a loop of catgut or Chinese silk, in order to snare the silkworm-gut, is used in the introduction of the sutures. The sutures are all introduced from within outward in order to avoid wounding the intestines with the point

of the needle, and the free ends of each suture are held in the bight of the hæmostatic forceps. When the sutures are all introduced, the flat sponge is removed and the central suture is first tightened. It is found that, as a rule, this makes a neater approximation of the edges of the wound. The sutures are fastened with perforated shot. The abdomen is carefully washed off with the solution of the bichloride of mercury (1–1000) immediately the wound is closed. There is then poured over the surface of the wound a liberal quantity of Keith's dressing (twelve per cent. solution of carbolic acid in glycerine). Over this are laid five or six thicknesses of Lister's gauze, and over the first thickness of the Lister's gauze (the one nearest the wound surface) is dusted a liberal quantity of pulverized iodoform or equal portions of iodoform and boracic acid. Over the Lister's gauze is then placed a thick wad of bichloride wool—that is, wool that has been wet with a solution of bichloride of mercury (1–1000) and thoroughly dried. Over this dressing is applied a bandage of opera flannel fastened with safety pins.

After-treatment.—For the first twelve hours after operation, the patient eats absolutely nothing. If, at the end of that time, the patient has rallied from her shock, and there is no hyperpyrexia or other symptoms of evil import, we commence to feed her with weak tea, ice-cold, giving two or three drachms every hour. This we have found by experience to be the best way of quenching thirst and furnishing gentle stimulation without overtaxing the stomach or producing nausea or emesis. At the end of twenty-four hours we commence the administration of food. This is preferably milk, if the patient will take it and the stomach retain it. If the stomach be irritable, we give koumiss or matzoon in place of milk. Unless the stomach rebel, the use of the milk is continued in half ounce doses with a little lime water, and after a few hours it is alternated with beef or chicken tea; on the fourth day, if the patient is doing well, we commence the administration of animal broths and soft food.

The dressing is never changed unless symptoms arise leading us to suppose there is something wrong with the wound, or trouble within the peritoneal cavity. The sutures are removed on the seventh or eighth day. Drainage is never employed, unless we have reason to fear tissue necrosis as the result of traumatism of the operation, or unless we fear hemorrhage into the peritoneal cavity. If symptoms arise which indicate drainage, it is a very easy thing to open the lower angle of the wound, and insert a drainage tube; where a drainage tube is used, glass is the preferable form. Great care must be taken to see that the mouth of the tube is thoroughly closed by a little tuft of the bichloride wool. When it is necessary to remove any fluid contained in the drainage tube, it is best done with the long uterine syringe, and after the removal of any fluid it is well to pour along the sides of the drainage tube a few drops of Keith's solution of carbolic acid and glycerine. As a rule, the patient is kept in the hospital for a week after the sutures are removed, and is enjoined from traveling any distance until a month has elapsed from the date of the operation. The bowels are moved, as a rule, upon the sixth day, preferably by a gentle saline. Recently we have found Rubinat water the best for this purpose, giving a third of a tumblerful as a dose.

Great care should be taken by the operator to know exactly how many hæmostatic forceps, instruments, and sponges are present in the room prior to the operation. It is the duty of the nurse to count over the instruments and have the count verified by an assistant both before and after the operation in order that the operator may avoid the distressing accident which has happened now many times, of leaving a hæmostatic forceps or sponge within the abdominal cavity.

The operation may be performed at any time, with the exception of the menstrual period, and five days before and five days after it.

Complications arising in the after-treatment.—A majority of the cases that die after oöphorectomy perish from sepsis. Where proper care is taken in the preparation and management of the operation to have everything about the patient, including the atmosphere of the operating-room, the patient's body and clothing, the instruments, the dressings, and, above all, the conduct of the operation in aseptic condition, experience has shown that an extremely small per cent. of patients die from this cause. Careful attention to the rules described in this paper will do a great deal to prevent trouble of a septic nature after the operation. Cleanliness is the desideratum, and this is not by any means attained by the use of antiseptic agents. Indeed, the best results have been obtained, not with the use of carbolic acid or corrosive sublimate, but by the use of distilled or plain boiled water. Personally, I take it that the use of carbolic acid is never justifiable, for it can never be used in solutions sufficiently strong to possess aseptic properties without

subjecting the patient to the danger of carbolic acid poisoning. Where, however, septicæmia does present itself it is best combated by reopening the abdominal wound and irrigating the peritoneal cavity with hot water. The septic hyperpyrexia is best reduced by the administration of antipyrin, and when once the temperature is gotten within the safety line it is best kept there by the administration of quinia. In desperate cases good results in the reduction of high temperature may be hoped for from the ice cap. Stimulants must be freely given, and opium or chloral in sufficient doses to control the nervous disturbance which is nearly always present. Where it is necessary to give opium or chloral it is best to give by the rectum, saving the stomach for the administration of food and stimulus.

Peritonitis following the operation is, I believe, generally septic in character; it is best subjugated by the use of salines. Shock after the operation requires the same plan of treatment employed in treating shock after any other operation. The usual means employed are, external warmth and the hypodermic administration of cardiac stimulants, as soon as the patient can swallow a few spoonfuls of hot coffee, will generally be found the best means to counteract the shock.

The Limitations of the Operation.—As this subject was the one which I had purposed bringing before the attention of the society for discussion to-night, permit me to give you the conclusions I have come to in the matter. I believe the operation is justifiable for the relief of ovarian pain, otherwise uncontrollable; for the artificial establishment of the menopause in cases of uterine fibroma characterized by rapidity of growth and exhaustive hemorrhage, and in which all other means have been tried unsuccessfully; for the cure of those cases of hystero-epilepsy which have well-defined menstrual exacerbations, and which have failed to yield to all other plans of treatment; and, finally, for those cases (which abound in every hospital for the insane) in which the mania or mental aberration is evidently dependent upon, or caused by, the act of ovulation. Indiscriminate, or what may be called hit or miss spaying, cannot receive too severe condemnation, and I doubt not but what the same obloquy and censure will overtake in the future the enthusiastic surgeons who resort to this procedure upon the slightest pretext, as overtook in the past those gentlemen who undertook to cure all the ills of suffering womankind by following the example of Baker Brown, in performing clitoridectomy.

Many of the methods herein described are already adopted by the mass of operators, but not a few of them are due to the ingenuity of Dr. Kelly, as I have before stated. The method of preparing the sponges originated, or at least was adopted, in the Pennsylvania Hospital some three years ago, and was brought to the attention of the profession in an article written by Dr. Thomas G. Morton, and published in the Philadelphia *Medical Times*, of November 13, 1886. Also the general subject of the technique of oöphorectomy has lately been well described by Dr. J. Craig Smith, in his work on *Abdominal Surgery*, published by Blakiston, in 1887; and likewise, also, in Hegar's *Hand-Book of General Operative Gynecology*, translated by Grandin, and published by William Wood & Co.

ON THE TREATMENT OF FŒTID CORYZA.

BY SOLOMON SOLIS-COHEN, A.M., M.D.,
PHILADELPHIA.

The obstinate "nasal catarrh," attended with excessive production of thick, discolored and offensive mucoid material, the discharge of which into the pharynx forms one of the most distressing symptoms, is a troublesome condition to treat; yet one which yields in greater measure than is commonly supposed, to active, intelligent, persistent, mild treatment.

I prefer the name proposed by J. Solis-Cohen—fœtid coryza—to the more recent term, "atrophic rhinitis," because the latter designation is not always applicable. I have seen quite a number of cases in which there was little or no atrophy of the turbinated tissues; although it is undoubtedly true that in the majority of cases there is considerable atrophy of these structures—often, indeed, the entire lower turbinated body, bone and all, will have disappeared almost without trace. The name ozæna, frequently applied to this affection, is sometimes made so general, and sometimes so restricted, that I prefer to discard it altogether.

The remarks concerning treatment, that follow, are not concerned with those forms of fœtid coryza which depend upon ulcerative processes, or the presence of calculi or other foreign bodies; in which cases removal of dead bone, or foreign body, is of course indicated, and the particular measures to be instituted will depend upon the extent and situation of disease. When there is but slight

ulceration, or beginning localized necrosis, scraping of the tissues, followed by cleansing and disinfectant measures, may alone be required.

In those cases where the nasal structures are as yet intact, or where there is simple atrophic change, the treatment, as a rule, is very simple; but it needs to be persisted in.

The first principle is cleanliness. No matter what the origin of the masses which are discharged, or which more often remain pent up in the nasal chambers, giving rise to offensive odors, their presence is an additional source of irritation, tending to prolong diseased conditions; and they must be gotten rid of.

Simply spraying the nose by means of an ordinary hand-ball atomizer will not answer. The nasal douche is apt to be abused, or used improperly, if entrusted to patients. The patient should be given an atomizer throwing a coarse spray, and directed to use some simple detergent solution, such as borax, soap bark and tar water, or even ordinary table salt in water (warm) thrice daily, in order to do what he can towards keeping the parts clean; but at first, frequent visits to the physician's office will be necessary in addition, for the performance of manipulations which the patient cannot exercise upon himself.

The passages should be first sprayed thoroughly with a coarse spray of a warm solution of hydrogen dioxide in distilled water (one part of a 15-volume solution to one or two parts of water), and then syringed with warm water, say 100° F., alkalinized with borax or baking soda, to which also a small quantity of the *liquor carbonis detergens* may be added. The syringing must be carefully and gently done, first through one nasal passage, then through the other, anteriorly and posteriorly; the latter procedure being accomplished by means of a curved nozzle reaching up behind the palate. With a little practice these manœuvres may be executed without discomfort to the patient. The masses loosened by spraying and syringing must be expelled by the patient's efforts, and the measures must be continued, supplemented if need be, by gentle swabbing with a cotton wad, until the nasal passages and pharynx are absolutely clean. The fact of cleanliness should be ascertained by rhinoscopic inspection. If the patient makes daily visits for the first two weeks, in an ordinary case, at the end of that time it will be found that it is both easier to cleanse the passages, and that the amount of material to be removed has considerably les sened. The patient will also report that he has had less difficulty in maintaining the cleanliness secured, by his own little performance with the hand-ball atomizer. According to the progress of the case, the patient may soon be instructed to call only every other day, and his own home procedures be augmented by direction to snuff up from the hand, morning and evening, warmed milk, containing a pinch of table salt. And as the improvement continues, the intervals between the active measures of the physician are gradually lengthened; until, in an ordinary case, at the end of six months the patient is able to keep himself comfortable by the use of the atomizer night and morning.

This persistent cleansing is the essential feature of the treatment. In addition, the individual conditions of different cases suggest a variety of measures. After cleansing, it is advantageous in cases showing signs of sluggish inflammation to apply to the nasal mucous membrane a solution of iodine and carbolic acid in glycerine (one grain each to the ounce) by means of brush or cotton-wad. Very often the insufflation of some disinfectant powder, such as iodoform or boric acid, or a mixture of the two, will materially assist progress.

When, notwithstanding the accumulation of fœtid mucoid or muco-purulent masses, there is reason to believe that the normal moisture of the nasal passages is deficient, the inhalation of the recent vapors of ammonium chloride is quite useful in stimulating the mucous membrane to healthy activity. Inhalation through the nose with exhalation through the mouth, is preferable to the ordinary method of inhalation through the mouth with exhalation through the nose. The apparatus required is very simple and may be constructed for ones self with a hand-ball and a few bottles and glass tubes. It is important to wash the vapor thoroughly to remove any excess of either hydrochloric acid or ammonia.

This measure is particularly serviceable in cases in which the discharge consists almost wholly of dessicated masses of epithelium desquamated in an immature condition. The inhalation of oxygen is often beneficial. Thymol, eucalyptol and other balsamic and antiseptic vapors may also be inhaled. A weak solution of thymol in alcohol may be shaken up with warm liquid cosmoline and the nasal passages sprayed therewith.

Internal treatment is sometimes indicated. In strumous children, arsenical preparations may be given, of which I prefer Donovan's solution. Iodide of iron and cod-liver oil are sometimes useful. Potassium iodide may be given, to cleanse the passages by the flux of an artifical serous coryza, sometimes with

quite happy effect. I usually resort to this measure at intervals during the course of treatment. Cubeb may be administered in the form of the oleo-resin dropped on sugar, or in pill of the recent powder, to gently stimulate secretion during its elimination by way of the nasal mucous membrane. Ten to fifteen drops of the oleo-resin of cubeb three times daily, after meals, is the ordinary dose for an adult.

Diet should be regulated. It is important to forbid patients, especially children and young women, to eat candy, pastry, and sweets. The prohibition must be absolute. Starchy foods should be reduced to a minimum. The functions of the digestive and excretory organs, including the skin, must be carefully watched and maintained at a proper standard. Exercise in the open air and hygiene in general must not be neglected.

By carefully maintaining general nutrition and vigorous function, with the topical measures already described to secure and maintain cleanliness, and such constitutional medication on the lines indicated, as the individual case may require, the case of catarrh that cannot be greatly ameliorated must be exceedingly rare; and what is practically a cure may be obtained in the majority of cases. As a matter of course, the longer the disease has existed the longer it will be necessary to continue treatment. A month for a year, and three months in any case is a fair rule.

It may be necessary for the patient to continue cleansing the parts by means of his atomizer as a part of his regular morning toilet; but that surely is a very little matter in comparison with the discomfort and annoyance which the possession of a fœtid coryza entails upon the patient and those with whom he comes in contact.

I have deferred until now the mention of the cutting, burning and boring methods, happily becoming less prevalent in the management of all forms of nasal disease, in order to mention my conviction that they have often converted a simple case of catarrh, amenable to the mildest measures, into very obstinate cases of the affection now under consideration.

219 South Seventeenth Street.

—Three deaths from yellow fever and seventy-seven from small-pox are reported from Havana, Cuba, for the week ended December 24, 1887.

WOUNDS OF THE CRANIUM.

BY JOHN A. HOUTZ, M.D.,

LOGANSVILLE, PA.

The cases I here report may prove of interest to the readers of the REPORTER, not on account of anything new in their management, but as showing the remarkable and unexpected results sometimes following seemingly hopeless accidents of this character.

Case I.—March 28, 1883, I was called to see a boy, J. W., aged four years, who had been kicked by a horse. I reached the patient about three hours after he had received the injury and found him unconscious, with a compound comminuted fracture of the right half of the frontal bone. The toe of the horse's shoe, which was quite long, struck about the centre of the right half of the bone, driving it into the brain in the form of an inverted cone. Sharp spicula of the orbital plate penetrated the coats of the right eye, and evacuated its contents. I removed all loose fragments of bone, of which there were many, the largest several inches in length, and including the orbital plate. As I removed the fragments, consciousness returned. Lacerated brain oozed out of the wound to the amount of at least a tablespoonful, while it was being dressed. Having removed all loose bone, and cut away the jagged edges, I syringed the wound thoroughly with warm carbolized water. The skin was then loosely approximated with silk sutures, allowing free drainage, and dressed with lint made of old linen rendered antiseptic with carbolized oil. A compress and bandage completed the dressing. The patient was seen and the wound dressed daily until April 22, and after that at intervals of a few days until May 24, when he was discharged, perfectly restored both as to mental and physical condition, with the exception of the loss of the eye and slight deformity at the site of injury. During the whole course of the case, the temperature did not once rise above the normal. He complained of no pain, had a good appetite, and slept well. At one time—I think about the second week—the dressing remaining on longer than usual, there was slight twitching of the left arm; but that disappeared on the renewal of the dressings. The general treatment consisted in a regulation of the diet, having his bowels regularly moved, and keeping him in a cool, quiet and darkened room.

Case II.—W. E., aged nineteen, was caught in a circular saw, March 28, 1887. On reaching him, about four hours after the occurrence of the accident, I found him in

the following condition: A saw-cut wound, extending nearly horizontally around the head from a point slightly to the left and above the occipital protuberance, around the right side of the head, above the ear, and ending below the right eye. From near the posterior point of the cut to the ear, the wound penetrated the skull and brain fully an inch and a half. The cut through the skull was a half inch wide. Brain was freely oozing out of the wound. Inside of the cranium, and in the brain, were hair, saw-dust, pieces of bark and parts of his hat. His left hand was cut entirely through the carpal joint, from back to front, leaving only parts of the soft tissues in front, not, however, severing the radial and ulnar arteries. The joint was laid widely open, and some of the carpal bones were cut into pieces. Hemorrhage was slight. The general condition was that of severe shock. He was comatose; extremities were cold; pulse was weak and irregular. When aroused from his stupor, he complained of pain more particularly in the hand and arm. I gave him, hypodermically, morph. sulph., gr. $\frac{1}{6}$; and atrop. sulph., gr. $\frac{1}{120}$, and small doses of alcoholic stimulants. The hair was carefully removed from the scalp, in the region of the wound. After being cleansed of all foreign substances and loose bone, and the sharp points of the skull cut away, the wound was thoroughly syringed with a 1 to 1000 solution of hydrarg. bichlor., and the scalp brought together with coarse silver wire sutures. The stitches were sufficiently far apart, over the brain wound, to allow free drainage. The dressing consisted of oakum, moistened with the bichloride solution sprinkled with iodoform, a compress of antiseptic cheese-cloth, and a bandage also washed in the antiseptic solution. After the first week, the moistened oakum was also saturated with carbolized oil, and a perforated tin splint put over the dressing to keep it in place. The wound at the wrist, after the removal of injured bone and dirt, was dressed in the same way, and the arm put on an anterior splint. The patient was seen daily, and the wounds thoroughly cleansed with the bichloride solution, and dressed as above stated, until the latter part of May; and after that, at longer intervals, until the date of his discharge, June 18. Antisepsis was carefully applied at all the dressings, and injured and protruding brain removed, either by syringe or by throwing a silk ligature around the base of the protrusion, and cutting it away with scissors. Altogether, several ounces of brain came away at the dressings, besides what was cut out by the saw at the time of the occurrence of the accident. After a few days, the patient's temperature rose to 103° Fahr., and continued for about four weeks at 102° to 103°. During all this time he was wildly delirious, the greater part of the time not recognizing his most intimate friends. His general treatment consisted in a restricted diet, purgatives and aconite to counteract inflammatory symptoms, morphia sulph. and potassium bromide to relieve pain and produce rest. Cold applications were kept continuously at the top of his head. When the patient began to grow weak, the aconite was gradually withdrawn, and the diet made more nutritious. The wound healed rapidly, so that at the end of the second week it was healed to the points where the skull was penetrated; and as soon as brain matter ceased to protrude, that part also closed; so that by the middle of June, the whole cut was firmly united. The wound of the arm also healed very rapidly, and with but slight suppuration. The joint is firmly anchylosed, and the power of extending the fingers considerably limited; but flexion is normal. He is able to grasp any ordinary object. By the time the wounds were closed his mind had entirely cleared up, and his intellectual powers seem as good as prior to the accident. He says he never has headache, and feels in every way as well as he ever did. He is now working on the same saw-mill on which he was injured, and is making a full hand. I attribute the successful issue of these cases largely to free drainage and antiseptics, which were as carefully applied in both cases as circumstances would permit.

REST IN SYNOVITIS OF THE KNEE-JOINT.

BY G. W. FUREY, M.D.,
SUNBURY, PA.

One evening in the latter part of May, 1881, I was called to see L. C——, nineteen years old, female. I found her completely exhausted by pain, fever, loss of sleep, and inability to take nourishment. Some of her relatives and members of the family were standing around weeping, while she lay moaning with pain one minute, and fainting into kindly unconsciousness the next. She had been able to take no material amount of nourishment for several weeks; and no sleep, except as induced by morphine. Examination soon revealed that I had to do with an acute synovitis of the left knee-joint. The last physician who had attended her had told the parents there was no hope, and that he

could do no more, but would see her again if they thought it of any use. It was evident that if anything was to be done, there was no time to waste, so I proceeded to prepare and apply a Baverian splint. The slightest jar in the room was intolerable to the patient, and, of course, the movement necessary to apply the cast caused great pain, as I did not dare to administer an anæsthetic owing to the prostration present. The patient was in a faint most of the time until the cast had assumed considerable stability, when she rested easier, complained less of pain, and, in fact, rallied just in proportion as the knee was afforded equable support and rest. Before the plaster-of-Paris had set, she had fallen off into an easy, natural slumber —the first for a month or more. Her pulse became stronger, her temperature more normal, and every one concerned felt better. It was ten o'clock when the limb was bolstered up with pillows in an easy position, and left to rest.

I remained till midnight, at which time I thought it best to rouse her up. As soon as she was fully awake, she looked around the room, and, with an eagerness that was pitiable, demanded some food. This I allowed her to have in moderation. After eating all I permitted, she expressed herself as feeling "first rate," and dropped away into a nice sleep, which lasted until morning.

At my second visit, twenty hours after the first, I listened to a full history of the case. She had fallen down a flight of seven stone steps seventeen weeks before, striking her knee; although not seriously hurt in other respects, inflammation of the injured knee soon set in, and it gradually became more and more painful and swollen. A physician was called, who remained in attendance for about four weeks, applying almost everything but rest. The case not getting any better, he was discharged, and I was called in. I was shown about a dozen bottles from which she had been taking medicine. Innumerable liniments, poultices, etc., had also been used; but no restraint of the mischievous contractions of the thigh muscles had been attempted, and the consequent flexion of the leg.

At my second visit the patient was complaining of considerable pain, and was rather depressed and discouraged. But when I assured her that the conditions were just what I expected and wished for, she brightened up. I removed the first splint with care, and, although occasioning considerable pain, soon fitted on another, which, of course, gave her immediate relief, and enabled her to sleep well all night. Sometimes it would be once a day, and sometimes every alternate day from this time on till the girl was able to sit up, that the diminution of the swelling would allow motion in the joint, and consequent pain, and I would have to put on a new splint. In three weeks she began sitting up, and in six weeks she was walking with crutches.

There was acute flexion of the joint at first, which I took the pains to reduce while applying splints, so that when I could make no further extension, it was at something more than a right angle. I now discarded the use of plaster-of-Paris, it having occurred to me that I could do with sole-leather splints all I could with the former, and something more, viz.: produce a leverage that by continuous effort would tend to strengthen the limb. This I happily accomplished in the following way: Making as much extension as possible, I cut out of heavy paper two patterns, one for the inner and one for the outer side of the knee. These I trimmed so that when their edges met in front and behind the limb, they neatly fitted to the same extent the Baverian cast had done. From these patterns I marked out on other paper the patterns I was after. This I did by increasing the knee-angle about three degrees. These latter patterns I used in shaping my leather splints. After making these pliable in warm water, I began at the lower part, and with a roller brought the edges together as I slowly and gently ascended the limb. There was not much trouble about it, and when it was at last "on," I was rewarded in seeing a straightening of three degrees. This method was pursued as often and as long as I could accomplish any improvement. It was the middle of August before the limb was as straight as it was safe to leave it, considering the obstinacy and inclination to remain stiff.

In September, while I was deliberating upon the expediency of giving an anæsthetic and forcibly breaking up the adhesions, her father suggested taking her to Philadelphia. I readily acquiesced, and gave him a letter to one of the leading surgeons of that city. She was there placed under an anæsthetic, and the joint was well manipulated. In a few days she returned to her home, bringing me a letter from the surgeon, suggesting that I continue to manipulate as before, confining the joint as it had been. I have no doubt this would have, in a reasonable length of time, resulted in complete restoration of the joint to a healthy condition; but the patient caught a severe cold coming home, which, in spite of all we could do, settled on her

lungs, and resulted in consumption, with which she died about a year afterwards. The knee trouble never occasioned any further discomfort or pain, however; and, although she was obliged to use a crutch or cane, she was thus able to get exercise and fresh air.

The only feature about this case that renders it worthy of being reported, aside from my plan of adjusting the leather splint, is the treatment—or rather the want of treatment this patient was subjected to for so long—seventeen weeks—by the two physicians who had it in charge at first. They endeavored to subdue the local disease with drugs; I did subdue it with *rest*.

Society Reports.

PHILADELPHIA COUNTY MEDICAL SOCIETY.

Stated Meeting, December 28, 1887.

The President, J. Solis-Cohen, M.D., in the chair.

After the reading of the papers by Dr. Charles Meigs Wilson and by Dr. Howard A. Kelly, published in this number of the Reporter, the discussion was opened.

Discussion.

Dr. John C. DaCosta said: Believing that many unnecessary operations are done, and that it is better practice to cure a woman and leave her with her organs intact, rather than by a brilliant operation to unsex her, without the certainty and with only the hope of relief, I took decided ground at the last meeting of this Society, in November, against the great number of abdominal sections now being made, including those made for "pain alone" (which is the subject for this evening's discussion), citing these cases to sustain my argument, viz.:

First. That a large proportion of the operations as done, and for the reasons alleged for operating, are unjustifiable.

Second. That the published reports of many cases said to be cured by operation are unreliable. For, though the operator may have been honest in thinking, when he made his report, that he had cured his patient, the after-history of the case sometimes showed failure.

Third. That the spaying of women for pain alone, and for many of the other supposed causes of trouble for which it is done, and in the miscellaneous way in which it is done, is unwarranted.

Having argued these points fully at the meeting a month ago, I this evening only restate my heads of argument, leaving the discussion to those gentlemen who have not yet had the opportunity to express their ideas.

Dr. W. H. Parish said: Twenty years ago very little was taught of the diseases of the tubes, and of any but the more bulky diseases of the ovaries. More recent experience and more recent literature are teeming with abundant evidence that diseases of the appendages, and more especially of the tubes, are of really the greatest frequency. Most usually the affliction is inflammatory in character, and dependent upon catarrh, gonorrhœa, or sepsis. I wish the readers of the papers had spoken of the prevention of these affections, and especially of the means of preventing inflammatory tubal and ovarian disease reaching that stage in which removal by surgical skill is indicated. The duty of the day is to point out the means of prevention rather than to permit professional interest to continue centered in the operation of removal. At the time when removal of the appendages is justifiable, sterility has been already established by the disease itself, and such treatment as will obviate that stage of progress of the disease which indicates surgical interference will also tend to lessen the probability of the establishment of sterility. What is to-day a mild inflammation of an appendage is liable—it may be very quickly—to become a condition even threatening life; and I am confident that some of the measures to-day directed by many against associated vaginal or uterine inflammation do frequently aggravate greatly a latent and subsiding salpingitis and ovaritis. Too irritating an application to a gonorrhœal endometrium will certainly convert a quiescent inflammation of the tubes into a pus-forming salpingitis. The same is true in reference to application made in other forms of endometritis. Gonorrhœa is the most important cause of dangerous salpingitis. The German writers pronounce the catarrhal form of most frequent occurrence, but they find this form most common in prostitutes, and we are most likely to assume, and correctly, that the disease in the prostitute is of gonorrhœal origin.

Hemato-salpinx often endangers life, inasmuch as rupture of a tube containing such altered blood as is found in that affection may originate fatal peritonitis. Now one of the causes of hemato-salpinx is stenosis by narrowing or by flexion of the cervical canal—securing the patulency of that canal may permit the tube to empty itself gradually into

the uterus, just as it does after opening up the vagina or uterus in hemato-metra and hemato-colpos. The inflammatory cases of tubal and ovarian disease are divisible into three groups: one of mild character, on which probably no one would operate for removal; another group, in which the accumulation of pus is so large and the symptoms so grave, that probably all operators would agree as to the necessity for removal; and then there is an intermediate group, in which surgical opinion would be at variance as to the propriety of removal. In this group the tubes and ovaries are in a condition of more or less subacute or chronic inflammation, with extensive adhesions, and probably some cystic degeneration. Physical examination does not always in these cases clear up the indications. The environments of the patient, the symptoms and the progress of the case, after prolonged judicious treatment, must as yet decide the question.

When, after removal of the inflamed appendages, the relief is not complete, or it may be there is no relief, the explanation is to be looked for often in the incomplete character of the removal,—a portion of the tube, especially the uterine portion, or a portion of the ovary, has been left, and this becomes the focus of other trouble.

There are sins of omission as well as commission in reference to this operation, and I believe that the profession has even yet more of commission resting on it. I am not an extremist, and have not operated for removal of the appendages many times.

Dr. Wm. S. Stewart said: I belong to the conservative class. Battey's operation is not a good one in general. There is danger in operating *per vaginam*. In one case we had a hernia. In one case I succeeded in passing a small sound up into a large abscess (of left tube), and recovery ensued after discharge of pus through the uterus. Those cases in which failure to give relief to pain is most evident, are those in which we are most justified in operating (as the results afterward proved). In one obstinate case in a single woman, with hypertrophied ovaries, and obliterated tubes, the patient was slow in recovering, but has at last reached a comfortable state. She was an intolerable sufferer; internal medication, either by mouth, rectum, or hypodermically had little or no effect. Relief promptly followed removal of the ovaries.

Dr. E. L. Duer said: I think this Society can endorse these papers as representing the advanced state of knowledge on these points. Dr. Kelly has emphasized for us the advantage of the educated touch. Dr. Coe, of the Woman's Hospital, of New York, states that but one-fifth of the ovaries removed are diseased. Pain is such a prominent symptom that it can hardly be called a neurotic manifestation. It is often due to adhesions or to pressure, excepting cases of gonorrhœal origin, or pus-containing tubes. This question has resolved itself to me into one of environment. The poor woman who must keep up and at her work, has no relief but by the knife. The rich woman who can be cared for, with rest, and favorable surroundings may be relieved, sometimes, for example, by the patient and persistent stretching of adhesions and restoring the circulation of surrounding parts.

Dr. J. Price said: It has been our custom to operate only for diseased tubes or ovaries, and we always find disease. Perhaps we cannot say that it will be abscess or pus, but it will always be disease. I do not believe that it is possible to diagnosticate everything until the abdomen is open. Dr. Emmet says: "It has been held that, as a rule, little evidence of previous cellulitis can be found when operating for the removal of Fallopian tubes." And that his experience confirms the accuracy of this observation. This has not been my experience. The adhesions have always been quite general when operating for disease only. Dr. Kelly refers to hemorrhage and Dr. Wilson to sepsis. Dr. Martin talks more about sepsis than any other operator, and his details of antiseptic precautions are quite elaborate. His mortality of twelve in seventy-two would stay Mr. Tait's hand. It is time to put this question in proper shape lest some good man be held criminally responsible for wisely and reasonably avoiding these solutions and dressings so highly lauded. We will take the statements of prominent operators. One is that "unless chemical or antiseptic solutions are used, the operator will be held criminally responsible." Another, that "men operating without solutions, is recklessness bordering on criminality." The opinion and practice of the skilled members of the profession will be incorporated in and make the law governing in all cases. Prof. Leopold has 110 completed ovariotomies—four died of septic infection (three to six per cent.), and he uses solutions. I believe that the great danger is from hemorrhage, not sepsis. The ovary and tube should be delivered, and this leaves but a small stump to be tied. I am not in favor of operating except for disease. He would not trephine for clavis hystericus or take out the eye for the agonizing pain complained of the next day by the same patient

who wants her ovaries removed for abdominal pain. We hear a great deal now of imperfect operation, necessitating a second operation. Mr. Tait and Dr. Keen have reported cases.

Dr. Sinkler said: The operation of removal of the ovaries is of great interest to neurologists, because many of the cases of hysteria and nervous prostration which came under their care are connected with pelvic pain or dysmenorrhœa. Besides Charcot's observations in hystero-epilepsy, relieving the paroxysm by pressure over the ovaries would seem to indicate that in such cases a cure might be expected from removal of the ovaries. The result of the operation, however, although satisfactory in some, is disappointing in a great many cases of this character. I have had under my care quite a number of patients in whom the ovaries had been removed for hysteria, neurasthenia, pelvic neuralgia, etc. One case, about twenty-three years of age, an extreme case of hysteria and a persistent masturbator, was under my charge at the Orthopœdic Hospital and Infirmary for Nervous Diseases. After seven months, being unimproved in every respect, she was discharged, and was taken by her friends to another hospital, where her ovaries were removed. After a few months she again came under my care, and I found her in as bad a condition as ever. The hysteria was as marked, and she masturbated very often. She did not improve in my hands, and I have recently heard of her, after an interval of nearly three years, in a worse state than ever before. Another case, is that of a lady of forty-two years, who, three years ago, had the ovaries removed for dysmenorrhœa, pelvic distress, and general neurasthenia. After a course of test treatment she has improved greatly; but it is an interesting fact that she still has attacks in which she says there is a sensation of uterine contraction and pressure, just as there was before the operation.

In conclusion, while I would hesitate to recommend removal of the ovaries for the relief of pelvic pain alone, I have no question in my mind that there are many cases of hystero-epilepsy and extreme neurasthenia dependent upon violent and prolonged dysmenorrhœa or ovarian pain, in which it seems to me that the operation is not very justifiable, but is decidedly indicated.

Dr. Chas. K. Mills said: The ground taken by Dr. Kelly can scarcely be attacked if, as I understood him, operation should be only undertaken, in the first place, when local disease can be clearly made out, and, in the second place, such disease can nearly always be recognized by proper methods of examination. Certainly, however, in very many cases of pelvic pain, no disease of the ovaries, tubes, or uterus can be recognized, or, indeed, is present. We have true neuralgias of these organs, as we may have of any viscus. Before too much significance be given to the ovaralgia of Charcot, it should be recalled that even in male hysteria, pain in one or the other iliac region has been met with in a number of reported cases. As to the view expressed by Dr. Wilson, that operation is sometimes called for when hystero-epileptic and other morbid phenomena are exhibited at or near the menstrual period, we should hesitate in accepting this dictum. All nervous symptoms are likely to be aggravated or excited in neurotic women at the menstrual period. In the *American System of Practical Medicine*, I have reported two cases of hystero-epilepsy in which the operation of oöphorectomy was performed. In one of these cases clitoridectomy was also performed. The hystero-epilepsy was not cured in either case. My conclusions are given in this work as follows: "With reference to oöphorectomy for hystero-epilepsy, or any form of grave hysteria, it may be concluded: 1. It is only rarely justifiable; 2. It is not justifiable in the case of girls who have not menstruated; 3. When disease of the ovaries can be clearly made out, by local objective signs, it is sometimes justifiable; 4. It is justifiable in some cases with violent nymphomania; 5. The operation is frequently performed without due consideration, and the statistics of the operation are peculiarly unreliable."

We have few reliable statistics with reference to the performance of pelvic operations for the relief of insanity. In these days, when operations are talked about in every house and almost on every corner, cases of ovarian monomania are likely to be met, cases in which the women are determined to be operated upon whether or not; some of these cases are undoubtedly like those of sexual hypochondria or monomania in man, in some of which self-castration is performed. In the wards of the Insane Department of the Philadelphia Hospital, is now a patient who has removed both testicles by successive operations, under the influence of such a monomania. Operation upon the ovaries or tubes, or both, in cases of insanity, should be restricted to those cases in which either local disease of long standing can be made out, or in which the outbreak of insanity can be clearly traced to disease or impaired function of these organs.

Dr. Keen said: In relation to hemorrhage, one little wrinkle may be of value. I have never had the ligature to slip from the pedicle; and this, I believe, to be due to the employment of this method: I pass the double ligature as usual, cut it in half, tie each half of the stump, and then, without cutting the ends, treat each ligature as follows: I thread one end through a needle, and transfix the tissue near by by this end, and tie a second knot. This fixes the ligature in place, so that it is impossible that it shall slip.

Dr. M. Price said there have been complaints of fistula lately—which may be due to imperfect method of introduction of the drainage tube. We usually introduce it well down into Douglas's pouch, well below the bowels. When there has been pus, we believe it to be necessary; if there be little oozing we remove it after a day or two, but otherwise retain it as long as necessary, and have never had occasion to regret it. I do not see what there is to fear.

Dr. Kelly said: The cases cited by Dr. Sinkler and Dr. Mills have a direct bearing upon my remarks, and show how important it is that the gynecologist should frequently seek the counsel of the neurologist. In reply to Dr. Price, I would state that a neglect of antiseptic precautions is criminal. The Society will not, however, understand me by this to refer in any way to a use of *solutions*, but to the antiseptic conscience, which is the creation of this generation, and in abdominal surgery often does its work as well with soap and water. The obstetric pad which I described, has long been in use at my hospital, and I know of nothing antedating my use of it. Extensive follicular degeneration of the ovaries never *per se*, requires operation, but this is often made necessary by the associated symptoms. All my cases have been benefited, while several continue to suffer from pelvic pain, they are entirely freed from the menstrual exacerbations, most have been raised up from chronic invalidism to perfect health, one attaining this not earlier than a year after the operation. In a case of epilepsy with most marked menstrual exacerbations and severe ovarian pain, the epileptic attacks continue, but she is free from pain, and Dr. Kerlin, under whose charge she now is, considers her improved.

Dr. W. W. Keen read a paper on

A Successful Cystotomy after Failure of Suction to Remove a Piece of a Catheter from the Bladder.

The recent suggestion of Dr. De Forest Willard, and Reginald Harrison (*Lancet*, Oct. 29, 1887) to extract foreign bodies from the bladder by the rubber bulb and evacuator of Bigelow's litholapaxy instrument, makes a valuable addition to our surgical resources in these troublesome cases, and is my especial reason for bringing to your attention to-night the following case. The failure of the method in this particular instance was due to special reasons.

J. W., a healthy man, aged seventy-five years, living in Elkton, Md., had suffered for a considerable time with recurring retention of urine, and cystitis following an enlarged prostate. Dr. Charles M. Ellis, his attending surgeon, very wisely taught him the use of the catheter, which he has employed daily for some months. The Nélaton catheter (No. 22 French), which he has employed, having lost its rigidity, he whittled a pine stick to the necessary size, and sought, by means of this, to introduce it into the bladder, November 7, 1887. In the attempt the catheter broke, and a piece, subsequently ascertained to be 4½ inches long, broke off and passed into the bladder. Severe pain and retention followed immediately, and persisted until after I operated upon him. Dr. Ellis, having failed in his efforts to extract the fragment, sent him to me, as the surroundings at his home were most unfavorable for any operation.

Three days after the accident I made similar and repeated unsuccessful efforts at extraction with forceps and lithotrites. I was not even able to detect the fragment.

On November 11th and 13th I attempted to remove it by suction with Bigelow's evacuator. On the last occasion Dr. Willard kindly helped me personally. We repeatedly filled the bladder with warm boiled water, being careful to keep the extremity of the evacuating tube just at the vesical extremity of the urethra, but suction had no effect in engaging the fragment. This was amply explained later by finding that it lay crosswise, and was so long that both ends were held fixed by the walls of the bladder, while the relative rigidity of the short fragment prevented any possibility of its being brought to the opening of the evacuating tube, though we sought for it through the tube by Dr. Willard's forceps. An evacuating tube with a lateral eye gave no better results than one with an opening at the end. I also used a rectal bulb filled with seven ounces of warm water, but all to no purpose.

After debating between suprapubic and lateral cystotomy, I decided upon the latter, in consequence of the observation of Harrison and others, that the prostate sometimes

shrinks after perineal cystotomy, when a tube is retained in place for some time. Accordingly Dr. Wm. J. Taylor etherized him, and I did left lateral cystotomy with a staff. The operation presented nothing unusual. The prostate was markedly enlarged in its lateral lobes, so that I was barely able to get my finger into the bladder. With the ordinary lithotomy forceps I easily seized the fragment by the middle, removed it, and introduced a rubber drainage tube with a flange, by which it was easily retained in place by tapes. His temperature never rose above 99°, and in six days he went home, with my instructions to retain the tube in place for two months, and then to remove it and allow the opening to heal. By this means I hoped to be able to avoid the necessity for the subsequent daily use of the catheter.

December 5, after nearly five weeks retention of the drainage-tube in the bladder, I found that, owing to his feebleness, want of care and cleanliness, the tube was proving a source of irritation and slight suppuration. Accordingly, December 10, I removed the tube. In three days the wound closed sufficiently to cause him to void his urine by the urethra, and he was no longer obliged to rise at night to relieve the bladder. The prostate has shrunk to some extent, so that he no longer needs to use a catheter. Whether this will be permanent, or is only temporary, time alone will determine.

Dr. J. H. Packard, in opening the discussion upon Dr. Keen's paper, said: I have listened to Dr. Keen's account with much interest, and merely wish to call the attention of the Society to the value, in some of these cases, of the suprapubic operation. This is not taught in the schools, and is scarcely mentioned in text-books, except, perhaps, in the way of condemnation. While not an advocate of this procedure to the exclusion of others, I feel that it has been greatly undervalued, and allowed to fall into undeserved neglect. Especially in cases of foreign bodies, and when a long article is placed cross-wise, there may be difficulty in extraction through a perineal opening. Sometimes, either in these cases or in those of stone, such violence is inflicted upon the vesical wall as to increase materially the risk to the patient. I have seen instances in which I could not but think that a fatal result was largely due to this cause. As a rule (to which I know of but one recorded exception), the injection of seven or eight ounces of water causes the bladder to bulge up, the peritoneum being lifted away from it, so as to afford abundant space for direct entry into the vesical cavity. Through the opening thus made, the finger can be introduced and the cavity explored. After the removal of the offending body, the wound can be sutured, except just where the drainage tube—which I have always employed—is passed in. Through this tube the urine flows away freely.

When infiltration of urine occurs, it is, in my opinion, almost, if not quite, always due to the fact that the incision being made at a point too low down, the contraction of the emptied bladder brings the opening just behind the symphysis; the urine is thus obstructed, and finds its way through the meshes of the areolar tissue. Diminution in the volume of the prostate occurs after the suprapubic section, just as Dr. Keen states it takes place after the perineal operation. I could cite four or five cases in which I have noted this; it would seem to be due to the relief of pressure and the cessation of straining.

Dr. Keen said: In this case I had to deal with a known flexible body, and so there was no trouble in the case. But had it been a rigid body, I would have done a suprapubic operation.

GERMAN MEDICAL SOCIETY OF PHILADELPHIA.

Meeting of December 12, 1887.

Dr. Lawrence Wolff read a paper on

"Ptomaines,"

of which the following is an abstract:

He first referred to the long-known toxic effect of decaying cadavers, and to the fact that their toxic effect was attributed to a chemical poison rather than to the transmission of a special micro-organism creating a poison in the new soil. He quoted the work of Pasteur and others and their effects upon medicine. He argued for the specific action of the microbe, from the fact that albuminoids can be preserved indefinitely if protected from them, reasoning that an organized body does not bear within itself the means of destruction or decomposition after death. He stated that other basic substances generated during life, such as the vegetable alkaloids, have great similarity with the cadaveric base developed through the influence of bacteria, and dwelt on the definite relations necessary between agency and soil to develop certain products. He considers the action of bacteria a chemical one, in consequence of which complex molecules are split up into simpler

ones. He recognizes the albuminoids thereof as the necessary pabulum of the microbe; but denies the excretory character of the ptomaine, which he holds to be simply by-products of decomposition. He quoted at length the history of our knowledge of the ptomaines, and accorded to Dupré and Bence Jones the priority of discovery in the isolation of animal chinoidine. Sonnenschein and Sulzer next produced ptomaines resembling atropine and hyoscyamine, while Rorsch and Fassendre next separated a base giving some of the reactions of digitalin. Schwanert also isolated a ptomaine. Dr. Wolff next mentioned the labors of Francisco Selmi and his work in various poison cases, and those of Liebermann, who obtained a coniine-like ptomaine, as did Brouardel and Boutmy, who claimed for ptomaines the power of reducing potassium ferricyanide—a claim which was soon proven fallacious.

After again referring to the vast labors of Selmi, Dr. Wolff proceeded to the consideration of pathological ptomaines. He claimed by analogy that, as the action of alkaloids is determined by their chemical structure, so must that of ptomaines be. And as special micro-organisms produce specific bases, he argued that the type and course of infectious diseases could in this way be explained. Thus, he said, pathology has fallen to the chemist, as was predicted by the late Austin Flint. He laid stress on physiological experiments made with ptomaines, and contended that when once the specific poison of a disease is known, the antidote will be indicated by its physiological action. He referred to Nencki as the first who furnished pure ptomaines, and then to the exhaustive labors of Brieger, in regard to the poisonous action of peptones and the conditions favoring the development of ptomaines. Dr. Wolff referred to the tyrotoxicon of Vaughan, and laid stress on its importance as a forensic ptomaine, and one pathognomic of cholera infantum. He then in a *résumé* dwelt on the generally transient character of the ptomaines and their instability as chemical bodies. He asserted that the true pathological ptomaines will be found in the pulmonary exhalations, and stated that he is engaged on experiments with a view to test his theory.

In opening the discussion

Dr. Weed related a case of sausage-poisoning, in which the well known symptoms of gastro-intestinal irritation quickly followed the ingestion of the food, but disappeared on the second day. On the ninth day, an attack simulating cerebro-spinal fever appeared, with headache, vomiting, retraction of the neck, delirium, spastic contractions on irritation of all the voluntary muscles, acetonuria, and death by failure of respiration. The autopsy revealed only hyperæmia of the cerebro-spinal meninges. Now, in considering this case, the primary gastro-intestinal phenomena are readily understood to be those of local irritation. But those appearing after nine days, do they speak for a late intoxication, or for an infection after a period of incubation? Is there any known ptomaine which, introduced into the gastro-intestinal canal, would be so gradually absorbed, and so slowly eliminated, as to exhibit cumulative action at the end of so long a period?

Dr. Formad called attention to the fact that cadaveric poisons are volatile, so that the danger from dissecting wounds diminishes from day to day after death. Virchow and Von Recklinghausen advise waiting until the third or fourth day with the autopsy in all cases of infectious disease. And even healthy tissue, as in sudden death from accident, or taken from the living animal, is highly poisonous, if introduced under the skin. So too is the saliva, of which the serpent virus is but a specialization.

Another reason for delay is the fact that the less dangerous bacteria of putrefaction will ultimately crowd out the specific bacteria of the disease. He confirmed Dr. Wolff's statement that oxygen is necessary for the development of the bacteria—his investigations, made in conjunction with Professor Vaughan, upon the bacteria of diphtheria in milk, having illustrated this fact. In his opinion, bacteriology has as yet offered nothing absolute in the diagnosis of disease, except in the cases of anthrax, tuberculosis, and relapsing fever; and he hopes that chemistry will in the near future give us the pathognomonic principles of disease.

Dr. Mays said: It is not true that all animal poisons are the products of the development of micro-organisms, and cited as instances the toxic effects of saliva, its analogue the serpent-venom, and even the physiological peptones, when introduced under the skin. So too papaotin, of vegetable origin, in which no bacteriological agency is claimed, is identical in its effect with the rattlesnake poison. Could not, therefore, certain cases of ptomaiæmia be due simply to the presence of physiological materials in the wrong place: as, for example, the hydrated albuminoids in the circulation? The poison in Dr. Weed's case was probably the "Wurst-Gift" of Brieger, analogous in its effects to curare.

Dr. Wise called attention to the fact that certain savage nations live almost exclusively on the meat of animals which died a natural death, and whose meat is partially decayed—such as the nomadic Arabs and the Norwegian fishermen—without experiencing any ill effects.

Dr. Miller emphasized the element of susceptibility in the production of the phenomena of ptomaine poisoning, and cited cases, one of tyrotoxicon and one of post-mortem poison, in which only certain individuals experienced ill effects.

Dr. Rosenthal called attention to the fact that in the cases of ergotized rye and fish-pickle, vegetable and animal tissues furnish identical poisons, namely, propylamine and trimethylamine.

Dr. Seiler, in reply to Dr. Wise, said that immunity results from the habitual introduction of toxic elements into the system, as in the case of the poison of insects. He questioned whether the endemic leprosy among the Norwegian fishermen might not be in part due to the very habit cited.

Dr. Muehleck denied the toxicity of saliva, *per se*, quoting the authority of Frerichs, whose experiments showed his own saliva to have been at times toxic, and at others not, and attributed this difference to the demonstrated presence or absence of micro-organisms in the respective observations.

Dr. Collins expressed his belief that ptomaines are constantly produced in the body, and that auto-infection is prevented by the simultaneous production of antagonistic ones.

Dr. Wolff, in closing the discussion, said that in Dr. Weed's case the primary phenomena were due to direct irritation, while the later symptoms were of bacterial origin. There is a remarkable resemblance between ptomaiæmia and curare poisoning. As we are ignorant of the mode of preparing this drug, who knows but what decayed animal tissue may be one of its ingredients? In reply to Dr. Wise's remarks, he called attention to the fact that cooking decayed meat would drive off the volatile ptomaines, and kill the bacteria; and that when such food is taken raw, the process of digestion effects the same result.

—Dr. Gross, of Geneva, has lately experimented with himself in hanging. His experiments established that the sensations were only warmth and a burning in the head, without convulsions. Of course, his experiments didn't go very far.

Periscope.

Sudden Death in Typhoid Fever.

Dewèvre is reported in the *Medical Chronicle*, Dec., 1887, as saying that (*Archives générales de Médecine*, October, 1887) the frequency of sudden death in typhoid fever has been variously estimated by different writers; it probably occurs in four per cent. of the cases. It is most often met with between the ages of 22 and 25, being rare in infants and old people. It occurs in males more frequently than in females, the proportion being rather more than four to one, and often in those who have been previously robust. It is most common in the third week of the disease, the largest number of sudden deaths occurring in the medium form of the disease rather than in the severer or slighter forms. It does not appear that relapses are very favorable to its occurrence. In some epidemics it is more frequent than in others. M. Hardy considers quinine when given in large doses to be a cause of sudden death in typhoid. It generally occurs after some effort, movement, or emotion, and occasionally during sleep. In the majority of cases there are certain premonitory symptoms which foreshadow a fatal issue; but these may be entirely wanting. Amongst the most frequent may be mentioned troubles of the respiratory apparatus, *e. g.*, dyspnœa, the cause of which the most scrupulous examination fails to discover; it occurs and ends suddenly, and is accompanied by a sense of agony closely resembling uræmic dyspnœa. Severe bronchitis and pulmonary congestion are also met with. On the side of the nervous system, syncope and convulsions occupy the most prominent position, while delirium and insomnia are not infrequent. Sometimes suppuration or hemorrhagic otitis complicates the case. Contractures and paralyses of different kinds are also met with. Circulatory troubles occur next in frequency to nervous disturbances, and they play an important part in the production of sudden death, as will be seen later on. Albuminuria is a common complication. Tympanitis has also been known to cause a sudden and fatal issue in typhoid. Sometimes the patient dies suddenly, without any of the foregoing symptoms being present. The frequency of the pulse affords a reliable guide to the state of the heart muscle, especially if the arterial tension be at the same time carefully noted. Hayem regards intermittence of the pulse as significant of impending danger; but the author thinks the danger has been over-estimated, inasmuch as

it frequently occurs at the end of typhoid, and, according to him, indicates that convalescence is approaching. Of all the premonitory symptoms which may foreshadow sudden death, the author regards convulsions (which may be general or local, slight or severe) as by far the most significant of approaching danger.

Post-mortem Appearances.—In 48 cases no lesion capable of causing sudden death was found, but in all the others a sufficient cause was demonstrated. It is interesting to observe that in the great majority of cases the intestinal ulceration was in the process of cicatrization. In sixteen cases the heart was pale, soft, and of a "faded-leaf" color, with fatty and granular degeneration of the muscular fibres. In a few cases proliferating endarteritis of the smaller vessels supplying the walls of the heart was noticed. Myocarditis, endocarditis, ante-mortem coagulation, etc., have also been met with; also, embolism of the pulmonary artery in seven cases. Amongst other lesions may be noted bronchitis and pulmonary congestion and nephritis. Cases of sudden death in typhoid may be divided into two classes, viz., those in which the autopsy reveals pathological changes which are sufficient to account for death; these form two-thirds of the fatal cases. In the other class are those in which no satisfactory cause of death can be discovered. The author thinks that pulmonary embolism and cardiac thrombosis are by no means a common cause of death. Hayem thinks that a peculiar form of degeneration of the heart muscle is constantly present in sudden death from typhoid, the cement substances between the muscular fibre cells being softened. The author does not admit that this change is universal, for in many cases it cannot be found, while it is not unfrequently well marked in cases in which death has occurred slowly; it is also of very frequent occurrence in typhus fever, while in this disease sudden death is not at all common; the same applies to small-pox. In diphtheria, also, sudden death is rare, while cardiac degeneration is very common.

Landouzy and Siredey have advanced the theory that ischæmia of the cardiac walls, due to swelling of the cells of the endothelium of the vessels supplying the heart, is the cause of sudden death in typhoid; but this change is of limited extent, and cannot be accepted as a probable explanation.

—The St. Louis Medical Society is endeavoring to secure sufficient funds to erect a building for their meetings and library.

Distribution and Etiology of Abscess of the Liver.

Dr. D. H. Cullimore, basing his statements upon statistics taken from the Report of the European Army in India from 1870 to 1879, declares (*Med. Press and Circular*) that, in his opinion, the predisposing factors (the greatest of which is prolonged heat) being equal, if we possessed an accurate knowledge of the stations in India, or elsewhere in hot countries, where hepatic abscess is most rife, we should find that they are such as favor most powerfully the operation of chill. Secondary factors are such exercises as are conducive to injury of the liver, already in a state of irritative congestion,—a condition in which rest is essential to resolution and cure. He asserts that the conditions most favorable to chill are:

First. Great monthly, and great daily, and sudden variations of temperature, particularly if associated with a heavy rainfall, following great heat.

Second. Situations on large rivers, particularly in hot river valleys, the river being subject to annual floodings, soliciting exposure to wettings.

Third. Misty and foggy situations on the slopes of mountains with a great rainfall.

Fourth. Situations overtopped by hills, or in the vicinity of hilly or mountain gorges, bare rocks, or isolated hill tops, such being easy of access.

Fifth. Excessive rice cultivation.

A combination of several of these factors is especially dangerous. In the absence of such conditions, it will generally be found that a high mortality from abscess is associated with the presence of cavalry or artillery.

Thirty-five Operations for the Radical Cure of Hernia by Original Methods.

Arthur E. Barker, F.R.C.S., surgeon to University College Hospital, gives (*Brit. Med. Journal*, Dec. 3, 1887) the following statistics of these thirty-five cases, although he admits that it is too soon to speak of the ultimate results as regards permanency of cure:

Of the 29 individuals operated on, 7 have been lost sight of, 20 have presented themselves recently for examination, and 1 has been heard of through competent observers. Of the 3 other cases in which the rupture returned and a second operation was necessary, the result was palpably due in 2 cases to the rapid absorption of the carbolized gut in one,

and of kangaroo tendon in the other; and in the third, which was one of his earlier operations, he was conscious at the time of not having taken up enough of the walls of the canal in his stitches.

None of the remaining 20 cases which have been followed up to date, and in all of which silk has been used, show any sign of return of hernia so far. Three were seen quite well twenty months after operation, 7 between twelve and fifteen months also quite well, and 4 between six and twelve months. It may be interesting to note that in one case whooping-cough, nine months after operation, had failed to reproduce the rupture, but had been bad enough to bring down a hernia on the opposite side, which had been perfectly sound before.

The objects kept specially in view in dealing with the cases of inguinal hernia above mentioned have been:

1. To free the inguinal canal and both rings from the presence of the sac, so that accurate closure might be effected.

2. To strip the neck of the sac from the cord with as little disturbance of the vascular and nervous structures of the latter as possible.

3. To cut the sac across just outside the external ring, and reduce its tied stump well within the internal ring, fixing it there by the same ligatures which close its neck.

4. To close the internal and external rings and all the length of the canal firmly with strong silk sutures.

5. To leave the fundus of the sac undisturbed in the scrotum, so as to avoid damage to the cord, testicle, and their vascular and nervous supply.

6. To get union by first intention everywhere, so that the deep sutures shall remain unchanged, and help to permanently close and control the rings and inguinal canal.

7. To avoid the use of trusses except in cases of umbilical hernia.

The author states in a note, dated November, 1887, that since his paper was read before the British Medical Association, in August, 1887, he has added six other operations to the above thirty-five. Of these, one was femoral and four were inguinal. Of the latter, two were congenital. All healed by first intention, except one, in which there was free suppuration in the scrotum; but the patient, a boy, is now at home well; one is still in hospital, but is quite well. There has been a return of the hernia in two cases in addition to those mentioned above, one in a very fat woman (umbilical), the other in a young man who had been at very hard work without a truss ever since soon after operation.

Laceration of the Radial Nerve in Complicated Luxation of the Elbow; Successful Secondary Suture.

In the *Deutsche Zeitschr. f. Chirurgie*, xxv, 3, Dr. G. Ledderhose reports a case in which he operated on a patient thirty-two years old, who, four months before had sustained a complicated luxation of the right elbow-joint, with laceration of the radial nerve. The injury was followed by high fever and suppuration of the joint, and necrosis of the external condyle of the humerus. Recovery ensued, but with ankylosis of the forearm at a right angle, and complete paralysis of the radial nerve. The muscles supplied by the radial nerve were completely paralyzed, and exhibited marked reactions of degeneration. On laying bare the ends of the nerves which had been torn apart, the proximal extremity was found expanded and united with the capsule of the joint, while the distal extremity was likewise thickened and firmly adherent to the tissues surrounding it, so that the ends of the nerves were separated from each other by a space of from two and a quarter to three and a quarter inches. The ends of the nerves were freshened diagonally, and sewed together, the position of the arm being at an acute angle. The wound healed rapidly by first intention. After the first few days of the operation, the functions of the interossei returned, which before had probably only been injured through œdema of the hand. Eight months later, active extension first become possible. By careful after-treatment, consisting of massage and electricity, the functions of the muscles supplied by the radial nerve had nearly completely returned, but the arm was still ankylosed at an obtuse angle, and there was disturbance of sensibility over an area in the forearm the size of the palm of the hand.—*Deutsche Medizinal-Zeitung*, Nov. 28, 1887.

Caseine as a Basis for Emulsions.

In the *Bul. de la Société de Thérapeutique*, Nov. 13, 1887, Léger strongly recommends the use of caseine in preparing emulsions, claiming that when prepared in this way they may be called "milk in which the butter has been substituted by a medicinal substance." The formula which he recommends is:

℞ Ol. ricini (or any other oil) 20 parts.
Caseini saccharati.....q.s.
Aquæ destillatæ.....100-200 parts.
Aquæ menth. pip.....5 parts.

The saccharated caseine is prepared by mixing purified caseine of cows' milk with bicarbonate of soda and sugar.

THE

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CHARLES W. DULLES, M. D., EDITOR.

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MEDICAL TESTIMONY IN SUITS FOR DAMAGES.

Some of the peculiar aspects of medical testimony in suits for damages are illustrated, and some practical reflections are suggested, by a case which is now on trial in New York.

On January 6, 1888, a woman forty-one years old, and with the appearance of an invalid, came before the Supreme Court of New York, claiming $20,000 damages for the results of an injury caused by a fall in in the street, on January 13, 1884. The accident seems to have been caused by her stepping inadvertently into a hole about four inches deep in the street crossing. In support of her claim, Dr. Jas. W. Ranney testified that she had concussion of the spinal column; that before the accident she was an unusually strong, hardy woman; and that now it was only a question of time when she would die from the effects of her injuries.

The principal witness examined for the defence was Dr. N. M. Shaffer, who said he had examined the plaintiff, and could say positively that she had no disease or injury of the spine. There were no soft spots in the marrow, as Dr. Ranney testified. The spinal column was in its normal condition. Her only trouble was hysteria. Falling forward as she did, it was impossible for concussion of the spine to result. If the woman would collect her will power she could get up and walk as well as anybody.

From our appreciation of the skill and integrity of Dr. Shaffer, and from certain sidelights thrown upon this case by points in its history which have no medical interest, as well as from our acquaintance with a number of suits for damages to which this one does not appear unlike, we are inclined to the belief that the city of New York does right to interpose every legal obstacle to the claim for damages made by this woman. It is true that a physician testifies that she has been seriously injured, and that positive testimony usually carries more weight than negative. But it by no means follows because one or a number of medical men testify that an injury, inappreciable to the senses of the laity, is present in a given case, that it is so. Unfortunately, there are some medical men who, in the hope of gain, will become surprisingly acute in discerning such injuries; and there are more, who are so moved by sympathy, and so credulous of the assertions of their patients—and especially of their women patients—that it is not hard to get them to corroborate what the latter say, and to supply them with terms which prove impressive to a jury, for symptoms or conditions which are common and innocent enough.

Such things are happening every day; and it behooves those who have the opportunity to express the sentiment of the medical profession, to protest against a wicked, or an amiable, prostitution of its reputation to the uses of designing persons. As a class, medical men have the deepest sympathy for suffering, and are always ready to assist in securing redress for an injury. But they have no interest in robbing corporations on account of injuries which have never taken place; and they cannot be too careful to avoid becoming abettors of any scheme which may do an injustice if it succeeds, or bring shame upon them if it fails.

TETANUS FROM USE OF THE STOMACH-TUBE.

The *New Yorker Med. Presse*, December, 1887, brings to us, through several intermediate channels, the report of an interesting case of death following speedily the use of an œsophageal or stomach-tube. The patient was a man forty-eight years old, who had been treated seven years before for stricture of the pylorus. At the time when he came again under treatment, he was suffering with flatulence, pain, progressive weakness, and frothy vomit. His stomach was found to be dilated. It was decided to wash out his stomach, and a tube was passed down his œsophagus. Hardly was this down, when he became faint, and the instrument had to be removed. Two hours afterward his jaws became stiff, he could not open his mouth, his arms became rigid, pronated and flexed, and his thumbs were flexed in his palms. He retained his consciousness; but was in a profuse sweat. Gradually all the muscles of his limbs and trunk became rigid; his temperature rose to 113°, and he died cyanosed.

At the autopsy, the diagnosis of stricture of the pylorus and dilatation of the stomach was confirmed, and no lesion of the mucous membrane of the œsophagus could be found.

The presumption is that this was a case of tetanus, caused by the mere impression of the operation. It is analagous to a few other recorded cases in which tetanus occurred, for which there seems to be no explanation, except that it was largely due to a mental impression. A number of these cases are precisely like certain cases of so-called hydrophobia, in which no material injury, no infection can be supposed to have given rise to the symptoms, and in which the phenomena are only explicable by the assumption that they were due to a pure psychosis.

This assumption does not make the *rationale* of such occurrences clear; but it may prevent false notions in regard to their etiology. It may, therefore, be useful to call attention to this new illustration of the possible effect of a trifling operation which makes a great impression on the mind of the patient, in order to point out what may be at the same time a source of great danger and an occasion of false theories in regard to morbid manifestations. In the case mentioned above, perhaps no foresight could have prevented the catastrophe, and certainly none of the recently announced theories of the etiology of tetanus can explain it.

SUB-PUBIC LITHOTOMY.

At a meeting of Berlin surgeons, Nov. 7, 1887, LANGENBUCH delivered a lecture on what he called "Sectio alta Sub-pubica." Impressed with the dangers and inconveniences of perenial lithotomy, Langenbuch has for some years practiced, and advocated the merits of, suprapubic lithotomy. But even this has its dangers, namely, the formation of prevesical phlegmon, if the sutures placed in the bladder do not hold; and the inconvenience of obstruction of the catheter sometimes placed in the urethra for the purpose of drainage. Langenbuch therefore proposes opening the bladder, to remove a stone, by means of an incision between the root of the penis and the pubic bone. This incision should be cross-shaped, and should be made so as to not to implicate the corpus cavernosum or the vena dorsalis of the penis. On reaching the bladder, the venus plexus at its neck should be pushed aside. To give room, he suggests that the lower portion of the pubic bone may be chiselled away. After this—or without it—the bladder is to be incised; and then it can be thoroughly explored, and any foreign body in it can be removed. If this be found impracticable, Langenbuch advises proceeding at once to open the bladder above the pubes in the usual manner of suprapubic lithotomy. For drainage he proposes making a counter incision through the perineum, in which a drainage tube is to be placed, while another occupies the sub-pubic wound. In this way, the urethra is not used at all for drainage.

This proposition of Langenbuch he has never put into practice, and it is founded upon purely theoretical opinions. It includes two principal points: the first, approaching the bladder immediately below the arch of the pubes; the second, making a counter

opening through the perineum for drainage. Neither of these is likely to meet with general acceptance. As long ago as 1750, Pallucci proposed making a counter opening in the perineum for drainage after suprapubic lithotomy; and for about fifty years after 1758, Frére Côsme practiced it with results which satisfied him, and which were excellent for that time.

The sub-pubic route to the bladder may have some merit; although it is not easy to say wherein it adds to the chances of success which are offered by a properly chosen operation for stone by way of the perineum or by way of the hypogastrium.

ALBUMINOUS PERIOSTITIS.

Not long since, Prof. Ollier, of Lyons, whose special studies in diseases of the bones and joints have been so extended and so thorough as to entitle his opinions to the greatest weight, described as a special form of periostitis that in which the affection is not accompanied by the formation of pus, but simply of a watery, albuminous, sometimes of a yellowish fluid, in which fat globules are present. This form of periostitis is sufficiently common; and certain German surgeons soon published observations and opinions corroborative of those of Ollier in regard to its features and its peculiar character.

But it is questionable if it be an advantage to attempt to set apart as a peculiar form of disease—except for conciseness of description—one which has a common origin and a common history with other varieties of a well-recognized class. It is not surprising, therefore, to find so accomplished a surgeon as Prof. Roser, of Marburg, protesting (*Centralblatt für Chirurgie*, Dec. 10, 1887), against the distinction made by Ollier, and endorsed by Riedinger, and Schlange in Germany, in regard to so-called "periostitis albuminosa." In the brief paper referred to, Roser shows that this form of periostitis has been fully recognized and well described before Ollier discussed it, and that it is so far from being a special disease that he himself has found it in the left tibia of a patient who had an ordinary osteo-myelitic abscess in his right tibia.

We share the opinions of Roser in this matter, and think it a mistake to attempt to make a special class of cases of periostitis in which there is no pus formation—except, as stated above, for mere convenience of description. For it may be desirable to have a short term, by which to express the difference between periostitis with pus-formation and that with the accumulation of a watery, albuminous, and sometimes fatty fluid beneath the periosteum. If this be all that is implied by the expression "periostitis albuminosa," we cannot see any harm in it.

VARICOSE VEINS IN THE TONGUE.

At the meeting of the Berlin Medical Society, November 23, 1887, Dr. Lazarus presented a patient who had a dilatation of the veins of the dorsum of the tongue. The patient had applied for treatment on account of expectoration of blood. There were no indications of lung disease in his physical condition, or from his family history. In examining his pharynx, Dr. Lazarus discovered at the base of the tongue, on the left side, far back, a bluish swelling, about half an inch wide, and extending to and upon the epiglottis. The patient said he had had, years before, a varicocele; but at the present time he had no evidence of it, or of any other varicose veins than those in the tongue. Treatment addressed to the pharyngitis granulosa, which the patient had, was successful; but the varicose veins remained unaffected by it.

The interest in this case is connected with the danger of hemorrhage from sudden rupture of the varicosity; the difficulty which might be experienced in checking it; and the possibility of an error as to its source.

NUTRIENT ENEMATA.

Prof. Ewald, of Berlin, has recently made some careful experiments with different nutrient enemata (*Deutsche Med. Woch.*, Dec. 1, 1887), and has found that enemata of eggs were of decided service; and that they were as efficient and satisfactory without being peptonized as when they were subjected to this process.

Book Reviews.

[Any book reviewed in these columns may be obtained, upon receipt of price, from the office of the Reporter.]

DOCTOR AND PATIENT. By S. WEIR MITCHELL, M.D., LL.D., Harv., Member of the United States National Academy of Medicine, etc. 8vo, pp. 177. Philadelphia: J. B. Lippincott Company, 1888. Price, $1.50.

It would be impossible to do justice to this unusually interesting and very instructive book in the space we can spare for our reviews. Those who are familiar with the author's style need not be told that he has a peculiar faculty for putting facts which many people observe in a way which few people could emulate. He seems to take each reader into a sort of confidential and familiar relation, and to talk to him as a personal acquaintance. In this way he has succeeded, in the book before us, in putting what he was tempted, he says, to call "Lay Sermons" in a shape which is at the farthest possible removed from sermonizing. As we glance over its pages we find it hard to refrain from quoting some of his wise and kindly instructions or suggestions. But we will not anticipate the pleasure of our readers when they have the book in their own hands.

REPORT OF THE SURGEON GENERAL OF THE ARMY, for the fiscal year ending June 30, 1887. 8vo, pp. 107. Paper. Washington: Government Printing Office, 1887.

Most of this report is made up of matters of special interest to medical officers in the army. But there are a number of matters of interest, from the standpoint of hygiene and the diseases of certain localities, to medical men in general practice. We note, also, the fact that the number of medical officers in the army who are permanently disabled is becoming a cause of embarrassment to the efficiency of the medical department, and that the Surgeon General, Dr. Moore, urgently recommends that an increase of twenty assistant surgeons be authorized.

HEALTH LESSONS. By JEROME WALKER, M.D., Lecturer on Hygiene at the Long Island College Hospital, etc. Small 8vo, pp. 194. New York: D. Appleton & Company, 1887.

Dr. Walker has essayed a difficult task—to write a book that shall embody scientific truth in regard to matters of life and health in such a way as to interest and instruct children. He has succeeded quite well. The teachings of his book are sound and his style is interesting, most of the illustrations are very good, some of them are beautiful. A few are of questionable taste; on the whole we think this the best book of the kind which has been subjected to our criticism.

FEVER NURSING, DESIGNED FOR THE USE OF PROFESSIONAL AND OTHER NURSES, ETC. By J. C. WILSON, A.M., M.D., Visiting Physician to the Philadelphia Hospital, etc. 8vo, pp. viii, 210. Philadelphia: J. B. Lippincott Company, 1888. Price, $1.00.

This is an admirable book by one perfectly competent, from his experience in practice and in teaching, to prepare it. It is the substance of lectures delivered to the class of nurses in training at the Philadelphia Hospital, and embodies clear and useful instructions for the management of fever patients. These instructions are, however, applicable to almost any form of disease, excepting surgical cases. Recent experience prompts the suggestion that it would not be amiss to add to them some upon certain homely subjects, such as the ministrations of the nurse in giving food and in assisting in the acts of urination and defecation. These ministrations, if properly carried out, may be a great alleviation of the miseries of a severe illness; while, if carelessly or ignorantly performed, they may materially increase these miseries.

This by way of suggestion. As it stands the book before us can be recommended in the strongest terms to nurses and to physicians. It is well written and very handsomely printed; and its moderate price brings it within the means of all who need it.

A LABORATORY MANUAL OF CHEMISTRY, MEDICAL AND PHARMACEUTICAL, Etc. By OSCAR OLDBERG, Pharm. D., Professor of Pharmacy in the Illinois College of Pharmacy, and JOHN H. LONG, Sc.D., Professor of Chemistry in the Chicago Medical College. 8vo, pp. 435. Illustrated (with five plates).

The object of this work is to provide lessons for laboratory work in chemistry with especial reference to the preparations used in medicine in the United States. The execution of this plan is well carried out, the processes being simply and clearly described and confined to those having the most important bearing upon pharmacy and the practice of medicine. In the part of the book devoted to analytic chemistry we note that Moore's test for sugar in urine is not given. This, although by no means an exact test, is, within certain limits, a useful and satisfactory one. Here also we find album*en* (in urine), where we think album*in* a preferable term.

Throughout the book the quantities are given in parts, or in measures of the metric system. This is an almost universal custom in works on chemistry. We think it would be no disadvantage if the corresponding quantities in Troy measure had been placed with those of the metric system.

As a whole we believe this book to be worthy of strong recommendation; and we heartly congratulate the authors and the publishers upon its contents and appearance.

Pamphlet Notices.

Clinical Report of Surgical Cases Operated upon by Prof. A. C. Bernays. Reported by Dr. W. V. Kingsbury. From the *International Synopsis of Medicine and Surgery*. 8 pp.

Comparison Between the Surgical Diseases of the White and Colored Races. By Louis McLane Tiffany, M.D. From the *Transactions of the American Surgical Association*, 1887. 4 pp.

An Experimental Study of the Effects of Puncture of the Heart in Cases of Chloroform Narcosis. By B. A. Watson, A.M., M.D. From the *Transactions of the American Surgical Association*, 1887. 37 pp.

Rubella (Rötheln; German Measles) with a Report of 150 cases. By J. P. Crozer Griffith, M.D. From the *Medical Record*, July 2 and 9, 1887. 36 pp.

—Dr. Kingsbury's Report contains brief accounts of the more important operations of Prof. Bernays at the Surgical Clinic of the St. Louis College of Physicians and Surgeons, from September 22 to October 22, 1887. These include a resection of a rib,

extirpation of the tongue, laparotomy, Porro's operation (mother died in few days; child living), gastrostomy, nephrectomy (patient died in 18 hours).

—Dr. Tiffany has studied the comparative effects and results of surgical affections in the white and colored races during a period of thirty-four months, and in 4930 patients. Abscesses, spinal caries, keloid, inflammatory phimosis are relatively more common among negroes than among whites; congenital defects are more rare among negroes than among whites; suppurative troubles and diseases affecting the lymphatic system are more common among negroes than among whites; negroes bear surgical injuries and operations better than whites.

These interesting conclusions of Dr. Tiffany suggest, as he says, further study. His pamphlet is illustrated with a fine phototype of a remarkable case of keloid in a negro.

—Dr. Watson presents a very thorough and valuable study of the effect of puncture of the heart upon animals subjected to chloroform narcosis. He describes in detail the results of sixty experiments; forty of which were made on animals suffering from complicated traumatic injuries, and forty on animals healthy and uninjured. He concludes that puncture of the heart, especially of the right ventricle stimulates its muscular contractions; and that this is of advantage in dangerous chloroform narcosis; especially if a certain amount of blood is also abstracted with the puncture.

The views of Dr. Watson met with some criticism from his fellows in the Surgical Association; but they deserve careful consideration and perhaps a more favorable acceptation than they received when first announced. As a contribution to our knowledge of the phenomena of the hearts movements under mechanical stimulation they are of great value.

—Dr. Griffith's pamphlet contains the most complete summary of the history of rubella (or German measles) of which we have knowledge. It also contains a very clear synopsis of its symptoms and course; and—less than six lines in regard to its treatment. This is summed up in the injunction to give a light diet; to keep the patient in bed for a few days, if there is fever, and in the house for a week. Chilling of the body is to be avoided, and severe symptoms or complications are to be treated as they develop. Dr. Griffith says, that rubella is usually a disease of no danger whatever. This is no doubt true; but one of the saddest cases of which we have ever known was that of a child of a physician in Philadelphia, which had what was diagnosticated as German measles, followed by indubitable evidences of pus formation in various parts of the body, including the brain, with extreme and persistent contractures and long continued imbecility. Such a fact as this should be borne in mind in judging of the possible effects of what may seem like a trifling malady.

—The care of croup.—Dr. H. R. Wharton lectured, Dec. 22, 1887, before the Nurses' Training School, in the amphitheatre of the University Hospital, on the duties of nurses in the care of cases of croup, before and after the operation of tracheotomy. He showed his audience the different appliances used in the treatment of that disease, and the method of cleansing the tube which is inserted in the windpipe after the operation.

Correspondence.

Twisted Terms.

Ed. Med. and Surg. Reporter:

Sir:—Your "humor" column in the Reporter induces me to tell you what a good woman said to me three years ago. I am sure it will be appreciated by the doctors. She said, "I am so sorry for Mrs. ——, she has been a confirmed infidel for five years, not able to sit up at all. She had a sore, and the cantereen set in, and the doctors held a meeting over her, and thought her limb would have to be amphorated." And in a certain town in Orleans County, New York, an ignorant man given to struggling with big words, said to me, "No, I haven't been what you might call *well* in some considerable time. I consulted Dr. ——, and he told me my trouble was a stoppage in the seekerative ducat of the liver." I told him that, although I am a minister and not a doctor, I believed that particular ailment of the liver to be generally fatal unless attended to in its incipient stages!

Yours truly, J. W. Sanborn.

Lockport, N. Y.

Chewing and Swallowing Glass.

Ed. Med. and Surg. Reporter:

Sir:—At the risk of being considered over-credulous or easily deceived, I write you in regard to a novel case that recently came under my notice.

A negro man, named Bill Jones, 39 years old, recently visited this State. He says he has been eating glass since he was two years old. He has never been sick enough to require the attention of a physician. I saw him eat part of a lamp chimney while on exhibition, and took him to my office and saw him perform the same feat two or three times. Most people will not believe he eats the glass, but I know it is no trick of legerdemain.

If I am not mistaken, it has been the opinion of the profession, as well as of the laity, that powdered glass was sure to cause death if swallowed in any large quantity. This negro says he has eaten as many as five large lamp chimneys without stopping. He chews the glass about as fine as one would ice. He says he discharges it from his bowels in the same state as when swallowed. He never suffers from any pain in his stomach or bowels. Have you, or any of your readers, ever seen or heard of such a case?

Please don't say that it is simply a sleight-of-hand performance. *I know he eats the glass.*

Yours, truly, B. B. GRACY, M.D.

Smyrna, Tenn., Dec. 26, 1887.

[There can be no doubt that certain public performers have chewed and swallowed glass with apparent impunity, and we have no doubt that Dr. Gracy's observation is correct. If glass be chewed small enough, it would probably be a fairly safe, though not a very nutritious, article of food. Most people would find it impossible to chew the glass without cutting their mouths. But, if they succeeded in this step, there is no reason why it should not pass through the bowels. —EDITOR OF THE REPORTER.]

Experience with Antifebrin.

ED. MED. AND SURG. REPORTER:

Sir:—Not seeing much written, and seeing some inquiry about antifebrin, I have concluded to give the readers of the REPORTER my experience.

Case 1.—Wm. D., age 18, an epileptic, was just getting over an attack which left him with a terrible headache. I gave him four fifteen-grain capsules, one to be taken every three or four hours until he was easy. He took one at noon, and one at 4 P. M. His head was easy at 6 P. M., and he slept well. The next morning he had a slight headache, and took one capsule. He reported himself as cured that evening.

Case 2.—Mr. V. D., age 57; first stage of typhoid fever, with temp. 104°, pulse 80, and severe frontal headache. It was my first visit, and he lived near Wm. D. I had not been in the house long when he asked me if I had any of those capsules for headache that I gave to Wm. D. I said I had, and gave him a ten-grain capsule, which eased his head, made him sweat terribly, reduced his fever two degrees, and brought his pulse down to 56. I thought it was the antifebrin which reduced his pulse, but I found it was not, by leaving it off. I continued to give him ten-grain capsules every afternoon; gave one every three hours, and only one day did he have to take the third dose. He made a good recovery.

Case 3.—Mary B., age 19, has tabes mesenterica, with headache, dry skin, quick pulse, etc. I give her eight to ten grains of antifebrin nearly every afternoon, and never have to give the third dose.

I find in antifebrin a medicine which will relieve nearly every kind of headache, and reduce the temperature when there is fever. In the majority of the persons to whom I have given it, it has produced sleep more natural than that caused by opium or chloral.

Yours truly, S. R. HUMSTON, M.D.

Smithville, Ind., Dec. 30, 1887.

A Warm Friend.

ED. MED. AND SURG. REPORTER:

Sir:—For the past seventeen years the REPORTER has never failed to visit my office once a week, and we are not only old friends, but also fast friends. For these years it has been my constant companion. It has visited with me many hundred tedious and wearisome cases, and in the long hours of the sick room, it has been my instructor and assistant. In many difficult, dangerous and obscure cases, it has been to me a very present help in time of need, conveying to me the knowledge of cases of the same character that some other brother in the profession had had, and how he managed them. Though wearied with the press of business, and worried with its anxieties, I have always found time to read its plain, condensed, practical and often brilliant articles. I have been in the active practice of medicine for more than a quarter of a century, and have been all of that time a constant student; yet I feel the need of a good live journal as much to-day as I ever did. And I would urge my younger brethren in the profession to secure some good journal—preferably a weekly, and *my preference is the* REPORTER—and never let its subscription lapse while in practice. No physician can do justice to his patients or to himself without such aid.

Having been a reader of the REPORTER under its three managements, it may not be presumptious in me to state my idea of its value. The REPORTER has always been good—worth many times its subscription price. To be frank I think you have in many ways improved its usefulness—that its society, clinical and case reports are better, more practical in character and contain more of the resources of the profession. I also admire the spirit of conciliation manifested—the live and let live theory. Life is too short for bickerings; science is cosmopolitan; all of our resources should be freely divided with our brethren and the world.

Keep on the safe ground of well-attested experience in practice; give us all of the latest and best, and success for the journal in the future as in the past will be assured.

Yours truly, J. B. HATTON, M.D.,

Secretary U. S. Board of Examining Surgeons,

Red Oak, Iowa, Dec. 26, 1887.

Notes and Comments.

The Use of Ligatures on the Limbs During Surgical Operations.

In the *N. Y. Medical Journal*, December 17, 1887, Dr. L. M. Sweetnam, of Toronto, recommends the employment of ligatures in surgical operations in order to secure more rapid anæsthesia, with the employment of a smaller quantity of the anæsthetic. This procedure has been employed by other surgeons, and Dr. Sweetnam does not claim originality for it. The advantages of this method are stated to be:

1. But little time is lost in securing complete anæsthesia, and but little in waiting for returning consciousness before leaving the patient after the completion of the operation.
2. If the bands are applied ten or twelve minutes before the first incision is made, the operation will be a comparatively bloodless one, and the surgeon works more rapidly and more comfortably than he would if the hemorrhage were more severe.
3. Saving of blood to the patient.
4. If collapse appears to threaten the life of the patient, the removal of one or more of the ligatures can be relied upon to bring about a prompt reaction.
5. There is less vomiting and distress after the use of the anæsthetic.
6. The small amount of ether or chloroform used, from an economical point of view.
7. Fewer ligatures and compression forceps are required to control the bleeding.
8. Less embarrassment of lungs and kidneys, and lessened risk of serious injury to these organs if diseased.

Care is to be observed in employing this method where there is a history of purpura. The author also states that while the constriction may be kept up for two hours with perfect safety, it is well to keep the limbs wrapped in blankets, so as to prevent serious loss of heat.

Erysipelas in an Infant Three Weeks Old; Recovery.

T. B. Greenley, M.D., in a communication to the *South-Western Medical Gazette*, says that on October 10, 1887, he was called to see an infant three weeks old suffering from erysipelas. The disease first manifested itself the day before, and affected the labia. The parts were very much tumefied and indurated, which led him to regard it as a case of forming abscess. At this time the disease had not extended from its original site. The temperature was 102°. On October 12, the inflammation was extending towards the right hip, and erysipelas was then diagnosed; the temperature was then 102.5°. The tumefaction of the labia increased. Solution of acetate of lead was used locally; the other treatment consisting of chalk and bismuth was continued.

By October 15, the inflammation had extended upwards as high as the navel on the right side, and as low down as the knees on both sides. The temperature, however, had fallen to 101.5°. The lead solution was changed for hyposulphite of soda, for fear of lead poisoning from absorption. The labia were still greatly tumefied and hard, but with no sign of pus. The treatment with milk punch, which was begun two days before, was continued, with the addition of a small quantity of morphia, to procure quietude.

The next day the disease ceased to extend upward, but still continued to extend downwards.

By the 19th, the disease had reached the feet, which were greatly tumefied. The labia were not quite so much swollen and slightly less hard. The child rested and nursed well; the temperature was 100°. The same treatment was continued.

On October 23, the inflammation had disappeared from the feet, and the patient was convalescent.

Treatment of Middle Ear Complications of Scarlet Fever.

Dr. Samuel Theobald stated before the Clinical Society of Maryland, at its meeting on December 4, 1887, that in his experience he had obtained very little effect from the use of the tincture of iodine, or the oleate of mercury locally; but had found that atropia sulphate, grains four to f℥j, would give great relief. He usually drops five or six drops in the ear and keeps the child quiet for several minutes. He thinks he has seen cases of such inflammation cut short by this method of treatment. In addition to atropia he now intends to use cocaine. He does not think that external applications accomplish much. Atropia gives almost instant relief from pain, and if used early enough will often prevent destruction of the drum membrane.

At the same meeting Dr. Hiram Woods remarked, that cases of purulent otitis from scarlet fever are attended with more complete deafness than otitis from other causes, and that they are very hard to cure. The cavity of the middle ear is usually filled with granulations. Atropia gives almost instant relief if the drum is not ruptured;

but when purulent otitis exists and the drum is still intact, the best treatment is to puncture it and let the inflammatory material out.

Dr. I. E. Atkinson said, that the frequency with which the hearing may be saved depends upon the time of interference, and, that if the drum is punctured when bulging takes place, many cases of hearing may be restored. Objections to the idea of not performing tracheotomy in these cases, do not have the slightest force. If any lives were shown to have been saved by it, then tracheotomy should be practiced; but one hundred per cent. die. In diphtheria it should be performed because a certain number of lives are saved by it.

Necrosis of Temporal Bone and Rupture of Internal Carotid.

This case is related by Sutphen, in *Archives of Otology*, vol. xv, No. 4. A man of twenty-five years of age, who had suffered with an abscess in his middle ear from his fourth year, was suddenly seized with pain and right-sided facial paralysis, and then with paralysis of the left half of the body. Shortly after this, pains came on in the right side of the head, followed by giddiness and nausea. The abscess then discharged, and the symptoms for a while abated. Three months later he became worse, hæmorrhage occurred from the ear, and he died. *Post-mortem* examination revealed a sequestrum in the deep parts of the temporal bone, which had eroded the wall of the internal carotid as it entered the skull. The cavity, formed by caries of the temporal bone, was connected through the internal auditory meatus with an abscess of the overlying half of the cerebellum. Above and in front of this was found the remains of an earlier abscess, which was thought by the author to account for the symptoms of paralysis which had been noticed, which had disappeared, following the escape of pus from the fistulous opening under the ear.—*Centralblatt für Chirurgie*, October 22, 1887.

Treatment of Gleet.

The *Quarterly Therapeutic Review*, Oct. 1, 1887, says that Dr. Fred. A. A. Smith, Cheltenham, asserts that some years ago a captain in the army consulted him about a gleet he had had for a long time. Nothing seemed to do him any good; at the same time he was anything but a temperate man, and practically was a very bad subject for treatment. He ordered him an ordinary alum lotion to be used as an injection, and for medicine, acid. nit. dil., ♏xv; dec. cinchonæ flav., f℥j, t. d. Returning home from his club in the evening, he took by mistake a dose of the alum lotion, and used the acid mixture as an injection. The consequence was that he suffered great pain for over half an hour, but cured his gleet. Noting this, Dr. Smith tried on his next case, acid nit. dil., ♏v; dec. cinchonæ flav., f℥j, as an injection, t. d., and found his patient got rapidly well, and has since used this treatment in several cases with very happy results.

Multiple Ulcers of the Cornea following Exposure to Electric Light.

Mr. T. Phillips, Clinical Assistant to Moorfield's Eye Hospital, reports in the *Lancet*, December 3, 1887, the case of an electrician, twenty-four years old, who, while engaged in making observations of a very powerful electric arc, removed the usual protection from the eyes in order to make a better examination. His eyes were thus exposed to the action of the light for about four minutes. Nothing abnormal was noticed following this exposure until about four hours subsequently, when, on awakening from a sound sleep, he suffered from acute pain in and about the eyes, great intolerance of light, and inability to sleep. The patient's own statement was, "I am stone blind." Five days after the accident, he was still suffering from acute pain and dread of light, which was overcome sufficiently to permit an examination by a ten per cent. solution of cocaine. The anterior surfaces of both corneæ were affected. The right was dotted all over with small definite ulcers. The left had six such ulcers arranged in pairs of three rows disposed vertically. The appearance of these ulcers was similar to that presented by the corneal ulceration which occurs in states of perverted innervation of the eye. The ophthalmoscope revealed nothing abnormal.

The eyes were bathed with boric acid lotion, and a solution of cocaine and atropine applied night and morning. In the meantime both eyes were closed with pads smeared with boric acid ointment. The patient was well in two weeks.

Ointment for Syphilitic Psoriasis.

Mauriac recommends for the syphilitic psoriasis which affects the palms of the hands and soles of the feet, the following ointment:

Oil of cade,
Mercurial ointment.....āā ℥ij
Vaseline.....℥j
Mix.

NEWS ITEMS.

—Dr. W. Joseph Hearn, of Philadelphia, has removed to No. 1120 Walnut street.

—A dentist in Pittsburg, who pulled a sound tooth by mistake, has been sued by the man from whom it was taken for $200,000. When it is considered that a whole set of A 1 teeth can be had for less than one hundred dollars, the plaintiff does seem a little exorbitant.

—The New York correspondent of the Philadelphia *Ledger* says that the East river bridge has become to a certain extent a health resort. Physicians prescribe for dyspeptic patients, or for those who suffer with lack of appetite, a walk back and forth, once in twenty-four hours; and at certain hours of the day there is abundant evidence that the prescription is acted upon.

—There are about fifty small-pox patients in the pest house in San Francisco at the present time, and several have died, though the malady has generally been of a mild type. It is claimed the first case was brought there by a China steamer about three months ago. Four Chinamen are said to have died on the voyage, but, as the ship's physician failed to make a report of the fact, the ship was allowed to land her passengers without remaining in quarantine.

—A writer in the *Westminster Review* on "Physic in the Far East" states that in Japanese medical history women were early instructed in the art. They were, with other doctors, admitted to the concurrent practice of charms and incantations, and in 723 female professors were appointed to teach medicine to their sex. At present women are allowed to practice there, and two Japanese ladies who had obtained diplomas in Western medicine should not find any but the medical prejudice in their way.

—What may fairly be called an epidemic of sore throat has been prevalent in Edinburgh for some weeks. The sore throat is peculiar. There is much redness of the palate, fauces and tonsils, with a tendency to the formation of gray patches. The appearance is thus suggestive of the scarlatina throat, and the mode of onset simulates that of scarlet fever. It is, however, unaccompanied by an exanthem, and the febrile symptoms abate rapidly. Suspicion of infection through milk has been aroused, and observations are being carried out on the subject.—*Brit. Med. Journal*, Dec. 24, 1887.

—To one of his physicians, Dr. Timann, the German Emperor recently expressed the wish that he might find it convenient to take an apartment nearer the palace. On his frank reply that his means did not allow him to live in the most expensive quarter of the city, the Emperor quietly caused an apartment to be hired and furnished at his own expense, within three minutes' walk from the palace, so that he is now able to call him at a moment's bidding, an electric telegraph having been specially arranged to connect the Emperor's study with that of Doctor Timann.—*N. Y. Tribune*, Jan. 2, 1888.

—The London Temperance Hospital has been established fourteen years. In that time alcoholic stimulants have been resorted to in not more than five cases, and in these instances the results have proved no more successful than where the remedies ordinarily used in the hospital were employed. Up to the present time over 30,000 patients have been under treatment, more than 12,000 of whom were to a greater or less degree addicted to drink. Many of those seeing the good effect of this treatment have become total abstainers. In fatal cases there were fully one-fifth more deaths among non-abstainers than among teetotalers.

—There has been an overturning in the Medical Staff of the County Hospital of Chicago, due, it would appear, to political machination. The staff is now constituted as follows:

Dr. Chr. Fenger, Dr. D. A. K. Steele, Dr. A. J. Baxter, Dr. Albert B. Strong, Dr. A. E. Hoadley, Dr. W. T. Belfield, Dr. Truman W. Miller, surgeons; Dr. O. J. Price, Dr. A. J. Coey, Dr. Melins, Dr. A. C. Cotton, Dr. John A. Robinson, Dr. J. P. Ross, Dr. P. J. Rowan and Dr. J. R. Brandt, physicians; Dr. Denslow Lewis, Dr. C. W. Earle, Dr. Charles Henrotin and Dr. John Guerin, gynæcologists. Pathologist, Dr. J. E. Colburn.

—On Friday, December 30, a meeting was held at the College of Physicians and Surgeons in New York city, for the purpose of organizing an American Physiological Association. The association has for its object the promotion of physiological research and of social intercourse among the physiologists of the country. The association will meet as a section of the Medical Congress every three years. The meeting was presided over by Dr. S. Weir Mitchell, and many prominent physiologists from all parts of the country were present. A constitution was adopted, and Prof. H. P. Bowditch, of the Harvard Medical School, was elected president, and Prof. H. N. Martin, of Johns Hopkins University, secretary and treasurer.

HUMOR.

A CORRESPONDENT asks "if it is really true that Job was troubled with boils?" There can be no doubt that he was if he had them.

A STRANGE THING: Jones—Strange thing, Mirandy; every time you draw a breath somebody dies. Mrs. Jones: Well, I ain't going to stop breathing on that account.

DR. BIGBILL—You may thank your stars, sir, that physicians in these days don't bleed patients afflicted with your malady, as they used to. Patient (dubiously)—I'm not so sure that they don't, doctor.

AN ENGLISH JUDGE is said to have laid it down from the bench in 1882 (see *Times* report, October 4 of that year) that "liars may be divided into three classes: Liars, great liars, scientific witnesses."

SMITH—HELLO, JONES! you don't look very well this morning. Jones—And I don't feel as I look. Got up in the middle of the night to take some pills, and swallowed four collar buttons before I found out the mistake.

NO CONFIDENCE IN THAT DOCTOR.—Wife (to third husband)—"If you feel so unwell, John, I think we had better send for my old family physician." Third husband (somewhat hastily)—"No, my dear, I would prefer to send for some one else."

"HELLO, NOBSON, you're not looking well." Nobson—"I am under the weather. Have had to leave off smoking, too." Johnson—"That's bad, that's bad." Nobson—"But that isn't the worst of it. I am dreadfully afraid that leaving off smoking is going to do me good."

OBITUARY.

BALFOUR STEWART, LL.D., F.R.S.

Professor Balfour Stewart was educated at the Universities of St. Andrews and Edinburgh. He had been in turn Director of the Kew Observatory, Secretary of the Meteorological Committee, and Professor of Natural Philosophy in Owen's College. He was fifty-nine years old.

DR. CHARLES T. WIDNEY.

Dr. Charles T. Widney died in Los Angeles, California, on November 6, 1887, at the age of forty-five years. He was born in Kentucky; educated at the University of Louisville; served during the war as surgeon in the southern army; afterward was for a few years in private practice, but spent most of his professional life in charge of private asylums for the cure of the alcohol and the opium habits; in which special field he was eminently successful.

SIR GEORGE BURROWS.

Sir George Burrows, formerly Physician to the St. Bartholomew's Hospital, and Physician in Ordinary to the Queen, died in London recently, at the age of eighty-six.

CHARLES LANGER, M.D.

Dr. Charles Langer, Professor of Anatomy and Director of the Anatomical Institution in the Vienna Faculty of Medicine, died on December 8, 1887, of chronic disease of the lungs.

CHARLES G. POMEROY, M.D.

Charles G. Pomeroy, M.D., died in Newark, Wayne county, N. Y., on the 14th day of December, 1887, in the 71st year of his age. Dr. Pomeroy was one of the most distinguished members of the profession in central New York. He was a permanent member of the American Medical Association, and of the State Society; a member, and one of the founders, of the New York State Medical Association; Ex-President of the Medical Association of Central New York, and of his County Society. As a citizen he stood high, and had the confidence of the community in which he had resided nearly fifty years. D. C.

Official List of Changes in the Stations and Duties of Officers serving in the Medical Department, U. S. Army, from Jan. 1, 1888, to Jan. 7, 1888:

Major P. J. A. Cleary, Surgeon, granted leave of absence for one month. S. O. 138, Dept. Ariz., Dec. 25, 1887.

Capt. R. G. Ebert, Assistant Surgeon, ordered from Fort Custer, Mont., to Fort Pemlina, D. T. S. O. 301, A. G. O., Dec. 30, 1887.

Capt. A. H. Appel, Assistant Surgeon, granted leave of absence for twenty days. S. O. 1, Dept. Mo., Jan. 3, 1888.

First Lieutenant C. B. Ewing, Assistant Surgeon, granted one months' leave. S. O. 137, Dept. Mo., Dec. 27, 1887.

First Lieutenant Wm. B. Banister, Assistant Surgeon, ordered from Fort Lowell, Ariz., to Fort Wingate, N. M. S. O. 3, A. G. O., Jan. 5, 1888.

Official List of Changes of Stations and Duties of Medical Officers of the U. S. Marine Hospital Service, for the week ended Jan. 7, 1888:

R. D. Murray, Surgeon, on being relieved at Ship Island, Miss., to proceed to Key West, Florida, and assume charge of the Service. Jan. 4, 1888.

S. C. Devan, Passed Assistant Surgeon, relieved from duty at Port Townsend, W. T., to assume charge of the Sapelo Quarantine. Jan. 5, 1888.

A. H. Glennan, Passed Assistant Surgeon, relieved from duty at Key West, Florida, to assume charge of the Service at Port Townsend, W. T. Jan. 5, 1888.

P. M. Carrington, Assistant Surgeon, promoted and appointed Passed Assistant Surgeon from Jan. 20, 1888. Jan. 7, 1888.

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Communications.

DENTAL IRRITATION AS A FACTOR IN THE CAUSATION OF EPILEPSY.[1]

BY ALBERT P. BRUBAKER, M.D.,
PHILADELPHIA, PA.

In all the wide divergence of view as regards the nature of epilepsy there is a general consensus of opinion that its essential feature is of the character of an explosive discharge from the higher nerve-centres, the nerve-force thus liberated bearing down upon the centrifugal distributions of the motor nerve-tracks with such an excess of energy that inco-ordination of movement reaches the stage of convulsion and spasm. Owing to the periodicity of the convulsive seizures, it has been assumed that in individuals predisposed to epileptic attacks the higher nerve-centres are in a state of high tension, of unstable equilibrium, and that it only requires a stimulus of a definite quantity or intensity to excite the explosive discharge.

Writers have generally laid it down as an established fact that the majority of the cases of epilepsy are idiopathic, without definite causation, and due solely to heredity; but it can scarcely be doubted that these cases are properly so classed only as regards the predisposition, and that in them all a morbid action, even though slight in amount, is necessary to call forth the nervous discharge. The morbid process may be centrally located and beyond the reach of investigation, or it may be peripherically located and excite the convulsion in a purely reflex manner. It is fully conceded by all that injuries to nerves, diseases of the ear, intestinal worms, phimosis, uterine troubles, etc., are all not uncommon peripheral causes resulting in epileptic attacks.

The question has been raised, however, as to whether a convulsive attack due to a peripheral irritation can be regarded as a true epilepsy, and whether it is not to be regarded rather as of a hysterical character. Without attempting to pass judgment upon this subject, it will suffice to quote the recent views of a very competent authority upon nervous diseases, Prof. H. C. Wood. In commenting upon the convulsion due to a peripheral irritation, he says, "It is almost invariably epileptiform in its general symptoms, and may conform exactly to the typical epileptic attack;" and, while admitting that many of these reflex convulsions partake largely of the hysterical character, he further says, "There are, on the other hand, convulsions which conform to the epileptic type, and which are the result of an organic peripheral irritation."[2]

A remarkable feature of the epileptic convulsion is its periodicity. Now, it is proved beyond question that the higher nerve-centres of the brain act not only as inciting, but also as inhibitory centres to those of a lower level. They are at once reservoirs of nerve-force and regulators of its dispensation. If, therefore, a morbid process at the periphery continuously attack, through nervous intermediation, these higher nerve-centres, it follows that these in time must have their resisting power overcome at intervals and at successively higher levels, until a final one is reached, when control is no longer possible. The unremitting irritation having at last overcome the resisting power of the highest nerve-centres, their energy is suddenly liberated and the organism is flooded with waves of uncontrollable centrifugal energy, until

[1] Read before the Philadelphia Neurological Society, December 19, 1887.

[2] "Nervous Diseases and their Diagnosis."

exhaustion brings about a temporary equilibrium.

The object of this paper is to direct the attention of physicians to a cause of epilepsy which has not hitherto been estimated at its full value, inasmuch as in none of the standard works upon neurology is the subject even alluded to, viz., pathological state of the dental structures. That dental inflammations and disorders are more often provocative of epileptic seizures than is commonly supposed appears quite certain from the following cases, and also from the character of the cause and its effect. Many reasons might be given why dental disorders are peculiarly adapted to call forth this periodical discharge, and why these disorders are habitually overlooked by the physician, but they need not be detailed here. As exemplifying these phenomena, some interesting and instructive cases are adduced.

The following case occurred in the clinical service of Dr. Wharton Sinkler, at the Orthopædic Hospital and Infirmary for Nervous Diseases, to whose kindness I am indebted for the privilege of recording it:

Case I.—Mary L., aged 9, was brought to the hospital in October, 1886, with a history of epilepsy dating from May of the same year. The convulsive attacks first made their appearance on the afternoon of the same day that the child had had three teeth extracted on account of repeated attacks of toothache. One decayed tooth, however, was left remaining in the lower jaw. Previous to coming to the hospital, the epileptic attacks occurred two and three times a week. From all that could be learned from the mother, the symptoms were those of a typical epilepsy. There was no neurotic history in the family. She was placed upon from three to five drops of the fluid extract of cannabis indica for two weeks, during which period she had twelve attacks. The bromide of sodium was then given for two weeks, during which she had sixteen attacks. From November 1 to March 1, 1887, she continued taking the bromides alone, in combination, and, finally, in conjunction with the infusion of digitalis. During the four months of steady treatment she had forty seizures. About the 1st of March the mother made the remark that the child was always extremely restless at night; that she would lie awake for hours complaining of toothache; and even when asleep she would continually grind her lower teeth against the upper teeth. Examination of the mouth revealed a carious and inflamed condition of a molar tooth in the lower jaw on the left side.

From the history of the case, and the possibility that the irritation arising from the diseased tooth might be the exciting cause of the attack, it was concluded to have the tooth removed. This was done under the influence of nitrous oxide gas. The night following the child rested much better, and from that time forward her sleep became natural, her appetite improved, and her general health became decidedly better. From the last week in February until the present time (December 19, 1887) she has not had a single symptom of an epileptic attack.

That a dental irritation should be capable of exciting an epileptic condition does not appear at all strange when it is fully comprehended how numerous are the recorded cases of ocular, aural, visceral, muscular, and nervous disorders which have been caused by the irritation arising from the pathological conditions of the teeth and associated structures.

The interest aroused by the result of the preceding case led to an examination of medical literature for reports of similar cases. I find that no less than sixteen cases, entirely and immediately cured by the removal of an irritating tooth, have been recorded by different observers, and which are here arranged in chronological order. It is not supposed that this collection embraces all the recorded cases, but it is hoped that it will elicit references to many others, and, what is more important, the reporting of many new cases.

The injurious effects of diseased teeth, and the irritation arising from them, in the production of many general diseases, did not escape the acute mind of Dr. Rush. In a paper published in his collected works[1] he records the following:

Case II.—"Some time in the year 1801 I was consulted by the father of a young gentleman in Baltimore who had been afflicted with epilepsy. I inquired into the state of his teeth, and was informed that several of them in his upper jaw were much decayed. I directed them to be extracted, and advised him afterwards to lose a few ounces of blood at any time when he felt the premonitory symptoms of a recurrence of the fits. He followed my advice, in consequence of which I had lately the pleasure of hearing from his brother that he was perfectly cured."

Dr. Ashburner published,[2] in 1834, a number of remarkable cases of hysteria, spasms, convulsions, etc., due to diseased conditions

[1] Enquiries and Observations, vol. i, p. 199.

[2] On Dentition and some Coincident Disorders, p. 98.

of the teeth. Among others was the following case of epilepsy:

Case III.—A young lady of highly nervous temperament was attacked with epilepsy in the eighth month of her first pregnancy. She had two attacks before her labor, which was a very favorable one. Seven months afterwards the fits reappeared, and occurred two and three times a week. Various methods of treatment were resorted to without success. For a while the intervals between the attacks were somewhat longer, and for a while they appeared twice daily. An examination of the mouth revealed seven carious teeth, which were at once removed. Three wisdom teeth were prevented from erupting on account of a cartilaginous condition of the gums. These obstacles were removed. The epileptic fits at once ceased, and after several years they had not returned.

Case IV.—Albrecht relates[3] the case of a boy, aged 12 years, who for a period of six months suffered daily with general convulsive attacks. Just preceding the attack there was severe pain in the temporal region. No cause could be assigned for the seizures. Treatment was without avail. Examination of the mouth revealed an overcrowded condition of the teeth, which were in addition unusually large. After removal of some of the teeth the convulsions subsided, and in a short time entirely disappeared.

Case V.—Dr. Tomes publishes[4] the following: "A lad, a farm-laborer from Windsor, was admitted into the hospital for epilepsy. The usual remedies were tried for six weeks without effect. His mouth was then examined, and the molar teeth of the lower jaw were found to be much decayed, and of some of these only the fangs remained. He did not complain of pain in the diseased teeth or in the jaw. The decayed teeth were, however, removed, and the fangs of each were found to be enlarged and bulbous from exostosis. During the eighteen months that succeeded the removal of the diseased teeth he had not suffered from a single fit, though for many weeks previous to the operation he had two or three per day."

Case VI.—Dr. Baly records[5] the history of a case of epilepsy from dental irritation, occurring in a man, aged 45. The patient was an employée in the Millbank Penitentiary; was of good physique; in good health, and had never suffered from vertigo, headache, or any form of nervous trouble. In the latter part of October, 1850, he began to suffer from toothache. On November 4, the tooth was examined by the medical officer, but on account of its carious condition and deficient light it was not extracted. Nitric acid, however, was applied, which gave the patient relief. On the 6th the muscles of the right side of the face began to twitch. The muscular spasms lasted four or five minutes, and occurred three or four times a day. "At these times, when the twitchings had reached a certain degree of intensity, the jaw became locked, and he lost the power of speech; but he had no pain in the head, giddiness, or sense of stupor. The paroxysm of spasm in the muscles of the right side of the face and jaws recurred the next day, and on the following day, the fourth after the examination by Mr. Chatfield (the medical officer), the twitchings became more violent, and his jaw locked. He had the sensation of all his teeth falling out, and then lost consciousness. A strong convulsive fit ensued, which lasted half an hour; the same night he had a second fit." These attacks were described as presenting all the features of an epilepsy. A third attack occurred before morning. The next day the tooth was extracted, together with a small piece of bone attached to the root.

For one month the patient was perfectly well, but on the 7th of December, in the middle of the day, he again experienced the spasmodic twitchings, and at the same time became conscious of the existence of something protruding from his jaw; with his fingers he removed a piece of dead bone. In the evening of the same day the spasmodic contractions of the face occurred several times. On the night of December 8, he awoke with a spasm in the cheek, and upon getting out of bed fell upon the floor unconscious; a general convulsive fit followed, during which there was foaming from the nose and mouth. At 6 A. M. a second fit followed, more violent than the first, and lasted five minutes. In the intervals of these attacks there was considerable uneasiness and confusion of mind. The next night he suffered a return of the fit. Examination of the mouth revealed a swollen and tumid condition of the gum, but there was no discernible source of irritation. The patient was placed on calomel to prevent further mischief to the deeper-lying structures around the diseased tooth-socket. He remained well until February 22, when he had, for the space of ten minutes, the same premonitory twitchings in the muscles of the face, but no real fit. A small piece of dead bone was extracted from the gum, after which the old

[3] Casper's *Wochenscrift*, 1837, p. 125.
[4] System of Dental Surgery.
[5] *London Med. Gazette*, xlviii, p. 534–540.

wound healed, and the patient entirely recovered.

In 1857, Dr. Sieveking read[1] before the Royal Medical and Chirurgical Society a paper entitled "An Analysis of Fifty-two Cases of Epilepsy." In the discussion that ensued Sir Charles Locock said he had noticed the omission in the paper of a very common cause of epilepsy, viz., dentition. He could not agree with Dr. Ashburner that all cases of the disease could be cured by the removal of the teeth; but he had certainly seen the affection cured in more than one instance by removing overcrowded teeth.

Case VII.—Dr. Ramskill publishes[2] the following: "A boy, 13 years old, has had frequent attacks of epilepsy for the last eighteen months. Latterly, his mother noticed that some days he rubs his left cheek, complaining of face-ache, after which the fit follows. On examining the mouth, there is to be seen a molar tooth considerably decayed, with a swollen gum around it and partly growing over into the cavity; it is not very tender to the touch, and the examination does not give rise to toothache. On questioning, I find the sensation which the boy experiences before the fit does not seem to be one of pain, but rather of indefinite uneasiness. He always has a fit the night this comes on. He never felt it during the day; it is always about seven or eight o'clock. I desired the mother to have the tooth extracted, and ordered a simple saline, with ¼ grain of belladonna, to be taken twice daily. This was in June. The tooth was extracted next day. I saw this boy once a fortnight from that time for four months, but he had no recurrence of the fits. In this case I believe an unfelt aura commenced about the gum surrounding the tooth, and was not recognized till some degree of inflammation arose, and thus a modification of pain became associated with the aura and directed attention to it."

Case VIII.—Trousseau relates[3] the case of a patient, a young notary's clerk, under the care of Dr. Foville, who had been subject to monthly attacks of epilepsy for several years. Many remedies had been tried in vain. Dr. Foville suggested the extraction of some carious teeth which ached constantly. The suggestion was acted upon, and from that day the fits disappeared.

Case IX.—Dr. Garrett related the following case before the Suffolk District Medical Society, and was reported by Dr. Page:[4] "A man, aged 40 to 50 years, had suffered with his teeth for years; these had been extracted and artificial ones substituted. He became paralyzed in the muscles of his face and tongue. There was a peculiar drawing of the mouth, from which the aura epileptica came just previous to the fit; the tongue was inclined to fall back within the mouth; he was fearful of swallowing it. In investigating the case Dr. Garrett removed the false teeth, and found the soldering discolored; he went back to his dentist, had a rubber plate made, and had no further attacks of epilepsy; the paralysis gradually subsided."

Case X.—W. H. Waite reports[5] the case of a young woman, aged 18, who consulted him for treatment for a carious condition of the incisor and canine teeth of the upper and lower jaws. The teeth had been diseased for four years, and were very sensitive. For three years the patient had been subject to epileptic attacks, which were at first quite slight, but had gradually increased in severity. After removal of the diseased teeth and filling of others, the epileptic fits entirely ceased. After some months the fits returned, attended with sharp, shooting pains in the alveolus. Examination showed that several other teeth had become decayed. These were removed, and from that time on there was no recurrence of the epilepsy, and the patient increased in health and weight.

Case XI.—Dr. Nathan Field reports[6] the case of a boy, about 5 years old, who was suddenly seized with an epileptic fit. In two weeks he had a second attack, which passed away after a few minutes. In the course of the next ten days it was estimated that the boy had a thousand convulsions, occurring every few minutes. No cause could be assigned. It was finally observed that before the appearance of the convulsion there was a twitching of the muscles of the left side of the face. Finally, after a severe convulsion, while the child was unconscious, he drew up his upper lip, when it was observed that the canine tooth had, instead of causing absorption of the deciduous tooth, pushed it outward through the alveolus, the gum, and into the lip. The tooth was removed, and in less than an hour the convulsions subsided and never appeared again.

Case XII.—Mr. Canton related[7] the history of the following case: A strong, healthy boy, aged 19, who had become the subject of epileptic fits, applied to Mr. Canton for treat-

[1] *Lancet*, June, 1857.
[2] *Med. Times and Gazette*, 1862, vol. ii, p. 216.
[3] *Clinical Medicine*, New Sydenham Soc., vol. i.
[4] *Boston Med. and Surg. Journal*, Nov. 8, 1860.
[5] *British Journal of Dental Science*, 1863.
[6] *Western Journal of Medicine*, 1869.
[7] *Proceedings Odontological Soc. of Great Britain*, 1880.

ment. As the cause of the fits could not be ascertained, it occurred to him that they might be due to the eruption of a wisdom tooth. The gum was freely incised, and the crown of the tooth laid bare. From that time the fits never returned.

Case XIII.—Mr. Henry Moon related[1] the following case: "The patient, a girl, aged 21, was brought as an out-patient to Dr. Fagge, at Guy's Hospital, and he, finding that her teeth were in a very bad state, sent her to Mr. Moon. She had suffered from fits since she was fourteen, and lately they had become so frequent as to reduce her almost to the condition of imbecility. On examining her mouth, a third molar was found in process of eruption; this he lanced freely. Some carious teeth were extracted and others were filled. Treatment by the bromides of potassium was ordered at the same time. The result was that the fits entirely ceased from the day of her first visit to the hospital. The girl recovered her intellect, and although she was kept under observation for several months, she had no return of the fits."

Case XIV.—Dr. Schwartzkopf reported[2] the following case in the *Deutsche Monatschrift für Zahnheilkunde*, 1886: "A man, aged 27, suffered severe pain in the right upper central incisor, which was carious, and consulted a dentist, who filled it. Soon after this a swelling appeared in the hard palate, where an opening formed. The patient was now easy, but the tooth continued loose and tender when touched. The fistula also remained patent and discharging. Ten days after the tooth was filled the patient had an epileptic attack, and these recurred at gradually shorter intervals, until, at the end of eighteen months, they occurred several times a week. During this time the patient was treated with bromides, atropine, etc., but without results. The tooth was then extracted, the fistula healed, and the fits ceased, and at the time of reporting the patient had remained free from them for four years."

The two following cases are reported[3] by Dr. Liebert:

Case XV.—Emil S., aged 25, in good health and with no neurotic tendency, began to suffer with attacks of vertigo in February, 1883. These attacks lasted several minutes, after which the patient appeared perfectly well. On one occasion, however, the vertigo was so severe that he was compelled to sit down to keep from falling. On one occasion he lost consciousness. By April 25 the attacks had greatly increased in severity. On this day he had such a severe epileptic attack that Dr. Liebert was called in. The patient had been lying on the floor for fifteen minutes wholly unconscious, and most of the muscles of the body in a state of tonic contraction; the pupils were of medium width and insensible to light; there was also a fresh wound of the tongue. After careful inquiry, it was learned that just previous to the attacks the patient experienced a peculiar tickling or crawling sensation in the tongue, an inability to speak words distinctly, and some involuntary movements of the tongue. Immediately after there followed the giddiness, the fall, unconsciousness, etc. Despite large doses of the bromides, the attacks increased in frequency and severity. Finally, in June, he began to suffer with toothache. Examination of the mouth revealed several carious teeth, one of which was very sensitive to percussion. This was extracted, and from that moment all peculiar sensations and motions of the tongue ceased, and there has not been in the past two years a single epileptic seizure. This patient had in the four months several hundred attacks of vertigo and eighteen or twenty typical epileptic convulsions.

Case XVI.—Young man, aged 35, cabinet-maker. Began having epileptic attacks on February 3, 1862, which came on almost daily and with increasing severity. On March 5 he had twenty-three seizures. With the exception of toothache he had never been sick. Repeated inquiries elicited the information that from December, 1861, the use of his tongue was for some seconds, or even minutes, frequently rendered difficult, and this fact was coupled with a certain feeling of illness or vertigo. In the attack of February 3, 1862, these symptoms were exceptionally severe, the tongue being drawn to the right side and executing spasmodic movements. Immediately thereafter he became unconscious and fell to the floor in convulsions. The tongue symptoms were usually premonitory of the frequent subsequent attacks. Owing to the fact that the aura appeared to be connected with the mouth, it was determined to seek for the cause in that locality. As he had had toothache occasionally, several carious teeth were removed. The patient at once declared that he felt an unwonted freedom from a former oppressive feeling, and that he believed he would have no more of the seizures. His conjecture was correct, for he remained free

[1] *Proceedings Odontological Soc. of Great Britain*, 1882.

[2] *Journal British Dental Assoc.*, 1886.

[3] *Deutsche medicin. Wochenschrift*, September, 1885.

from them from that time forth. This patient had epileptoid vertigo for three or four months, and severe epileptic attacks for thirty-eight days.

STERILITY, ESPECIALLY IN SYRIAN WOMEN.

BY S. LOUISE WEINTRAUB, M.D.,
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During my three years' practice in Damascus, Syria, two-thirds of my patients came to me for sterility. The disgrace which in olden times caused Rachel to cry out to Jacob, "Give me children or I die," is still felt by Eastern women. A fruitful cause, it seems to me, is the early marriage common among them. Among the Moslems, whose doctrines have a very degrading and debasing effect on womanhood, girls are married when from eight to fourteen years old. Girls after eighteen being considered "old maids" are asked in marriage only by widowers of forty or over, and as second wives to men already married.

Amongst the Greek and Roman Catholic Syrians, from twelve to sixteen is the common age for marriage. A difference in age between the sexes of from ten to fifteen years is considered proper both by them and by Moslems. The Jews likewise marry early, but the sexes are more nearly of an age. A young wife is preferred, as she more readily conforms to the household of her father-in-law. The ancient patriarchal system still continues. The sons bring home their wives to their father's house as in the olden time. Each is allowed a room for himself and his family, and here they sleep, father, mother and children, side by side, upon beds made up for the night upon the floor, these beds being rolled up and put away in the day-time. But all the families eat together at the same table, as a rule.

The mother is the ruler and *chaperone* of the son's wives, she knowing where each one goes or what she does. This is her highest position, and when she has attained this place her home is assured as long as her sons live, it making no difference, or only very little, when her husband dies. But with the sterile woman it is different. Her condition often is a cause for divorce amongst Moslems and Jews, or the reason why a Moslem marries a second wife. If the first wife is very rich or beautiful, or much beloved, she would insist on a divorce if a second wife were brought to the house. To meet the case, a white slave is often bought, who is really a wife to the man, but occupies the position of a slave and obeys the whims of the wife. The children of this slave take the rank of the father, however, and are often much beloved by the woman who has not been blessed with children. As there is no such remedy as divorce amongst the Greeks and Roman Catholics, sterility frequently gives rise to cruel and unkind treatment from the husband.

Among Syrians the sterile woman experiences great hardships, and often fails to keep her husband true to her. She must bear his constant reproaches that she is useless, and often hear the complaining question, "Why should I save money when I have no one to inherit it?" The secluded life of a sterile wife often lacks the interest, love and occupation which children bring to the mother and a certain degree of liberty which she enjoys; while the men miss the highest honor that can be paid to them—to be called father of Salime, or whatever the first-born son's name may be. The honor of fatherhood is so great in the East that a Moslem will be sometimes called by the name of an imaginary son. The loss of this honor makes the men extremely bitter towards their wives, who are always considered to be the one at fault.

This condition of things causes women to to do everything that lies in their power in hope of relief, and they often endure great suffering in consequence. They go from midwife to midwife in their faint hope, and often become invalids for life, if they are not carried off by a sharp peritonitis or metritis. The shrines of various holy persons reputed to have helped others are visited, Moslem women tieing a little piece of rag on the window of one of the shrines, so that the holy one should remember them and grant them their prayer. I have often had to remove pledgets of some pungent-smelling drug, whose name I did not know, from my patients who came to me after having been to these various midwives. The patient frequently suffers intense pain from the treatment to which she is subjected, and the vulva and vagina become greatly swollen and inflamed; peritonitis, or cellulitis even, often resulting.

Some of the remedies used are cayenne pepper, onions, melted butter, garlic, raw meat, spices, mastich, mixtures of various raw drugs, dried flowers and plants of various reputation. Some of these are taken by the mouth, but most of them are applied *per vaginam*. A kind of sound is also used, which has been described to me as made of bone and being sharp-pointed. I have heard of one woman who underwent treatment with this

instrument, and died after a day or two, the uterus probably being perforated. There are certain drugs reputed among Moslems to produce boys, and are consequently frequently resorted to.

There are many Bedouin Gipsy women who go crying through the streets "medicine for sterility," fortunes told, etc., and many a desperate woman catches at this straw, only showing how great their disgrace is felt to be. A few have even overcome the custom of years, and have allowed a medical man to examine them. Any one who knows the belief of Moslems, and the great disgrace this is felt to be, will understand the significance of such a concession.

A frequent cause of sterility is the remains of a bad cellulitis or metritis, the result of some heroic treatment. Sterility often follows the birth of a child, and is due to the lack of proper care after parturition. Or when the patient has taken cold and a slight inflammation of the genital organs has followed, this has been greatly increased by injudicious applications made by a midwife, the result being a metritis or cellulitis.

In my practice, when I found upon examination that a woman who was sterile had no visible or serious hindrance to conception, one of my first steps in undertaking her treatment was to have the husband sent to a doctor, who would examine the spermatic fluid and send me a written record of the result. If that was as it ought to be, I would proceed with the woman's case. Frequently a small and undeveloped uterus seemed to be the only cause of sterility. In these cases I would use dilatation by sea-tangle tents. My mode of proceeding would be to order the patient to let me know the day that the menstrual period was finished. That day she went to the bath, and the next I would go to her house and introduce as large a tent as possible.

The following cases illustrate my practice:

Case I.—Greek, of the wealthy class, was married when fifteen years old, and is now over twenty-seven years of age. She has been under the treatment of numerous noted physicians of Beirut and Damascus, but never was pregnant. Her husband is a third son; his brothers and sisters have large families. Her own brother has also a large family, but one sister is sterile.

On examination I found her uterus one and a half inches in length, very small, but movable. Her menses were regular. There was no inflammation of the genitals, except a slight irritation of vagina. I treated her a few times, and then, on the sixth day of her menstrual period, I dilated the os uteri with a No. 1 sea-tangle tent. I found much difficulty in introducing it; but kept it in place with pledgets of cotton dipped in glycerine.

The tent was removed after eight hours, the patient not having moved all this time, but having lain perfectly quiet upon her back. That night there was connection, and the patient remained in bed three or four days. The husband was also under treatment. She did not become pregnant until the second menstrual period, when she conceived, and afterwards was delivered in due time of a fine healthy boy.

Case II.—Greek, aged eighteen years, married at the age of thirteen; has never been pregnant during the five years of her married life; menses regular and painless. Her husband was well developed and strong. In the section of the city in which she lived, the women are not allowed any liberty, and cannot go out until after they bear their first child. So this poor little woman was not allowed to go even to the bath or to church, except a few times. In all these five long years, her small dreary house was almost a prison—for the houses are very differently built in Syria from the way they are built in America. On examination I found her uterus very small, but movable and not inflamed. Her entire appearance was very girlish—even more so than is general amongst Eastern women. At the same time after the commencement of the menstrual period as was chosen in the former case, a tent was introduced, and this was followed by the same restriction to bed. She stayed in bed three days, and I did not allow her during the entire month to do any work. She became pregnant that same month and at full term gave birth to a nice little girl. I could give the histories of other similar cases; but these show some points of my line of treatment.

I found that I was successful when the patient had not been tampered with much by midwives, and if, at the same time, the husband had tonic treatment if he were not robust. Another point I found to be important was to introduce the tent directly after the menstrual period, before any connection had taken place, and to have connection accomplished immediately after removal of the tent. I also advised that connection should not take place within two or three days of the next menstrual period. If the menstrual flow did not appear then, I forbade any further intercourse until the uterus had risen out of the pelvis.

I think it extremely important that a microscopic examination of the spermatic fluid should be made before any effort of the kind I have described is made. For, in not a few cases under my observation, the men proved to be at fault, and were beyond hope of help, nothing being the matter with the women. The following case shows the advisability of observing the precaution:

Case III.—A young Bedouin woman came to me from a distance of two or three days' journey. Her husband was a Sheik and had had three other wives, but had had no children by any of them. She was very bright, and said she had often been told, if she would just step aside from the straight road, she could soon become pregnant. But in the free desert life amongst the higher Bedouins, virtue is the rule; and she would not do so. Examination showed her uterus and appendages to be in perfect condition. But on examination the Sheik was found to be entirely at fault. In such a case treatment with a tent might have been injurious and certainly would have been useless.

In my experience I have found that but little could be done for cases of old cellulitis or metritis. Treatment in cases of recent cellulitis was more hopeful, and even old cases were sometimes relieved.

Many of my successful cases I was unable to follow up, because the women were afraid I would expect some remuneration. I was frequently puzzled by not finding any visible cause for sterility in either my patient or her husband.

I had no results from the use of the sound, the introduction of which, two or three times a week, is advised in some text-books for the treatment of sterility. I also found that mischief might result from frequent introduction of the sound after intercourse between husband and wife. Women will become pregnant after long years of sterility. So I never used the sound except immediately after a period. The rule and custom in the East is that connection shall never take place until after the woman has been to the bath. Usually the eighth day is the one observed.

I have had no opportunity to test what effect electricity might have in such cases as we are considering. The frequent success of the treatment with tents was due, I think, to the fact that dilatation overcome the stricture of the internal os, and frequently started up a retarded development of the body of the uterus. Again, hardness of the cervix—a frequent cause of sterility—was often overcome by this treatment.

The fact that I never observed real or serious inflammation as a result of dilatation with tents was due, I think, to my never introducing a tent if the slightest tenderness of the uterus was present, or if the introduction of the sound was unusually painful. I also watched my patient carefully, never allowing her to get up if the slightest tenderness existed, and not permitting intercourse if the tenderness persisted for more than a day.

Though various plans have been suggested for treatment of sterility, it has seemed to me that there is very little positive knowledge on this subject. Of course, I treated inflammations with the regular remedies in use. But for many of my patients I was unable to do anything of the sort, for they did not seem to need it, and it did not help them. I should be very glad to have other ideas in regard to the treatment of sterility, on which so much of the weal or woe of Syrian women depends; for any physician, being among them, cannot help having his or her strongest sympathies aroused by the misery and unhappiness which this condition entails.[1]

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REMOVAL OF THE UTERINE APPENDAGES FOR DISEASE IN WHICH PAIN IS A PROMINENT SYMPTOM.[2]

BY HOWARD A. KELLY, M.D.,
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According to the request of the directors, that I should prepare a paper briefly discussing the operation for removal of the ovaries and Fallopian tubes in those cases in which pain is a prominent factor, and accepted as one of the indications, I have thus, although under great pressure from other work, gladly conformed to their wish, and here bring before my coworkers in other fields some of the fruits of

[1] As I am concluding this article, a letter reaches me from Jerusalem—which is ten days' journey by land from Damascus—asking my advice and treatment for sterility. This letter was originally sent to Damascus, the writer not knowing that I had left that city. The fact that it was sent there shows that a report of the success of my treatment had reached that distance. The anxiety of the Syrian women to become mothers is so great that they will undergo the fatigue of long journeys, or any inconvenience or loss which may be necessary, in order that they may consult a physician who has a reputation in this matter.

[2] A paper read before the Philadelphia County Medical Society, at a stated meeting, December 28, 1887.

my labors and thought in this unsettled territory of ovarian disease. In the brief time allowed I cannot read references and quotations, and will speak rather from my personal experience and of the results in cases, some of which have been traced for several years, and now may be referred to as permanently cured or improved. Only by *permanency* can any proper estimate be placed upon the value of reported results, and while successful cases are being reported in large numbers daily, within a few days or weeks of the operation, but little has been said of the condition in which the patients found themselves after one, two, and three years.

My opinion relative to the class of cases suitable for operation, to the results to be expected from operation, and as to the operation upon neurotic cases pure and simple, conforms closely to that expressed by Professor Hegar in his monograph, *Der Zusammenhang der Geschlechtskrankheiten mit nervösen Leiden und die Castration bei Neurosen.* Nearly as I agree with Professor Hegar, I differ very widely from many other "authorities," so called, in this much-contested field. Still more widely do I differ from many views which have gained currency in the profession at large, as to the indications for and against operation, the certainty and the permanency and the value of the results obtained.

The convenience of assuming the symptom *pain* as a characteristic factor of the group of heterogeneous cases we are about to consider is at once evident. With this symptom patients usually apply, and ask for nothing except that their *pain* be relieved, and under present modes of treatment and indifferent specialization in medicine, in cases even of marked disease of a minor character, the patient often goes through a protracted course of treatment in which nothing is distinct outside of the subjective elements of the case. *Pain* alone drives most patients to consent to adopt whatever means the surgeon may propose as remedial. By thus emphasizing this subjective feature, and also by the natural history of the diseases, we exclude all those cases from our study in which *size* is a characteristic.

We have left then a great group of mixed pelvic diseases lesser in size, but not in the elements of danger: causing more suffering, with greater certainty undermining the health, and in no sense less important than the large fibroid, dermoid, or ovarian cystoma, unless we measure disease by the tape measure. "What the eye sees not the heart grieves not," is true of those who find it so difficult to realize the great hourly danger in which their patients may be living, in whom nothing may be apparent to the eye, and but little to an unpractised touch.

Common among the diseases referred to are: ovaries enlarged by cirrhosis; ovaries with extensive follicular degeneration; hemorrhagic ovaries; ovaries containing pus sacs; neuralgic ovaries; ovaries involved in a withering of the pelvic peritoneum with the tubes, and tubo-ovarian disease, with co-existing hydro-, pyo-, or hæmato-salpinx. These three names, however, signify not the disease itself, but an accident of the disease, which may be absent and the disease still exist. Pyo-salpinx is a misnomer, as the disease may exist in all its essentials, and the tube contain no pus, but the ovary may be converted into a large pus sac. In my experience, abscess of the ovary with a tube much thickened, gelatinous and friable on section, but containing no pus, is quite as frequent as a large tube sealed and distended with pus attached to a small ovary simply enveloped in inflammatory products. I believe that the entrance of the septic material into the ovary takes place through a ruptured follicle. In a case upon which I operated one year ago, my patient married a man suffering from gonorrhœa; she experienced no difficulty until the time of her first menstruation, when she was seized with violent pains and remained an invalid ever after, until I removed the mass.

Hydro-salpinx is more commonly associated with some mild non-septic pelvic inflammation which has resulted in sealing the fimbria, and hydro-salpinx results. It may, by distention of the tube, cause pain; but the morbid process usually long antedates the formation of any tumor. If this were not the case, the rational procedure would be unquestionably slitting open the tube on its dorsum, careful removal of the fluid, and an attempt to establish a pervious uterine opening by passing a small canula into the uterus, which could be removed later per vaginam. The disease, however, lies back of this, and the fluid formed is but one of its sequelæ. Here at once is a reason why operations upon tubes thus enlarged are not always and at once successful in curing the patient of all disability.

I am at present making daily visits to a patient operated upon in the spring, from whom a large hydro-salpinx was removed, along with the ovaries and tube of the opposite side. Her uterus and structures lateral to it are now free from all sign of disease, but there still linger low down in the pelvis foci of inflammation in the cellular tissue,

which, although objectively small, cause a disproportionate distress to the patient. The operation was here an imperatively necessary step, but still only one step on the road to cure.

Hydro-salpinx is at times associated with anomalies in the development of the individual. Thus I operated last week in Chicago on a married woman, about thirty-eight, who had been a great sufferer ever since puberty. I found an infantile uterus, two very small white ovaries, that on the left side being no larger than, and of the shape of, my thumb-nail, while vaulted over it was a large tube distended by several ounces of watery fluid. The indication in this case was not the size of the tube, but the establishment of the menopause to relieve painful ovulation. In pyo-salpinx, on the other hand, the starting point and focus of the disease are often the intensely poisonous contents of the tube, which involve surrounding structures by successive invasions; and here, were it practicable, the disease might often be cured by removing the tube alone, leaving the ovary; but of such a conservatism I do not approve, as the ovary without its duct is useless, even dangerous.

Of hemato-salpinx I will not speak further than to say emphatically that I do not believe that all these cases are extra-uterine pregnancies, and to draw attention to the fact that the contents of the sac may be as acridly poisonous as that of pyo-salpinx, and should receive the same extreme care in removal.

It would be better if pain, *per se*, were never considered a sufficient indication for operation; or, at the worst, only those cases operated upon in which the most prolonged and painstaking care had failed to relieve, and where the intensity of the suffering must always seriously interfere with the capacity of the patient to enjoy life. We here meet the neurologist on common ground, and it would be better for all such cases if they first underwent a prolonged treatment at the hands of these specialists. A host of cases of neuralgic ovaries which have been sacrificed by the gynecologist would thus have been cured, and many cases which have been operated upon and not relieved would at least have been spared the ordeal of operation, and the too frequent reproach thus be spared the gynecologist, that he recommended the removal of a woman's ovaries, but she declined, and a nerve specialist afterward cured her; and, to make the reflection worse, she has since borne a child. I have a case in which a friend considered removal of the ovaries would be necessary some two years ago, so great were the patient's sufferings, but with the gradual compensating hypertrophy of an insufficient mitrally diseased heart, she has improved, and is now six months pregnant. A prominent factor in causing pelvic distress, aggravated at the menstrual period, is, I am now convinced, large varicose veins in the broad ligaments. I think I can almost always recognize these cases now by the character of the pain, the facies of the patient and a peculiar sense of boggy fulness to the vaginal finger. Constipation seems to be one factor in the causation, but while relieving constipation helps the condition, I have not found that it cures any case of long standing. Sequelæ of pregnancy may cause it. My experience as an operator leads me to reject removal of tubes and ovaries as in any way assisting a cure. In one case sent me by one of the most prominent neurologists in the country last spring, the patient is but little improved, although one of the veins tied and cut off was a half centimetre in diameter. As nothing else seems to do more than mitigate this condition, I propose yet to open the abdomen and simply tie the distended tortuous veins at either end, aspirating then, if necessary, and if the patient is no better she will at least be no worse off.

One class still remains, usually classed among the neuralgic cases, and this class Dr. S. Weir Mitchell has happily defined, giving appropriate form to an idea which I have for some time entertained—they are those cases in which the expectancy and concentration of the attention on a normal function leads it to simulate disease in the expression of pain. These cases, if operated upon, rarely reflect credit upon the operator, and should ever be considered more in the province of the neurologist than of the gynecologist. I have never operated on a case of this sort, and never expect to. I have been speaking somewhat briefly of cases in which pain is the only local manifestation of disease. There is a small group of cases in which general nervous phenomena of an aggravated character seem after a time to subside into a local disease. I have in mind a case of salaam convulsions which lasted many months, was followed by severe neuralgic pains in various parts of the body, then by severe pelvic pains, and at the operation small cystic ovaries were discovered, and the patient promptly and completely cured by their removal. It is impossible, however, for any but a specialist to distinguish with certainty between those cases in which there are no

manifest gross changes in these organs and the cases about to be described, in which the trained touch can with certainty and exactitude determine the nature and extent of such changes. I know by my own progress in this matter how impossible it is for any but the touch which is daily exercising, improving and correcting its inferences, to come to any definite conclusions in this matter, as to the size and position of the ovary and tube, whether cystic, how much enlarged, and if adherent. All these and other questions are but matters of daily practice for years to decide in all cases.

One of these cases I show you to-night was treated by more than thirty physicians, and had received almost as many differing opinions, no one recognizing the true nature of her disease, which I had the satisfaction of determining at once to be abscess of the ovary, the instant my finger swept over the vault of the vagina. Another patient was treated for fourteen years, and her physician, who lived in central New York State, recognizing some similar symptoms in a case upon which he saw me operating at my private hospital, sent her down to me, and she is now very much in the improved condition of the patient you have just seen. Here, also, I removed ovaries greatly enlarged by old encysted abscesses.

Briefly, then, as to the status of this operation—the removal of *diseased* appendages, small in size, but in which pain is a prominent symptom—as a scientific operation:

1. It is scientific, because it deals with *diseased organs*.

2. It does more than almost any other single surgical procedure in relieving a large number of cases whose sufferings have been almost unbearable.

3. In *properly* selected cases the percentage of recoveries is over ninety-five per cent., and improving, and the percentage of cures equally large.

4. Unless we adopt the yard-stick as our measure of disease, the indications for operative interference are often more urgent than in the case of most cystomata coming under our observation.

And, lastly, all the steps of the operation, the technique of the procedure, have now been so widely appreciated, that it may be described as a *safe* operation.

In marked contrast to this statement might be cited the case of Sir Spencer Wells, in the days when this operation was in its infancy. We can here readily discover one reason why Sir Spencer has always been so bitterly opposed to operations of this class. He operated upon a woman fifty years of age, for the purpose of inducing the menopause. In opening the abdomen the intestine was cut, the ovaries were not completely removed, and the mesentery prolapsed from the wound, and a bad hernia followed. Such was the result of an imperfect technique in the hands of one who in the generation past did more for abdominal surgery than any other man of his time.

Of all the questions relative to this work, that of *results* most nearly concerns us. As to the *immediate* results, life or death, I will speak of that under the title of Danger of the Operation. I refer here to the result relative to the *curing of the disease* in those cases which have recovered from operation. A satisfactory inquiry upon this heading will depend entirely upon the standard which we erect beforehand, by which to test our results. The brilliant results occasionally following this operation, and the many sanguine reports of operations in which the patients are reported to have been the most wretched of all sufferers, and by the abdominal section to have been at once and forever relieved from all pain, to have recovered health at once, and been able to return often to duties of a very laborious nature, have conspired to bring about such a state of professional opinion, that cases which cannot show these results are thrown back upon the operator as failures.

There was at one time, when this operation was dangerous, as in that cited by Sir Spencer Wells above, some reason for this opprobrium, and the results gained were measured by the danger passed through, and often found inadequate; but with the great diminution of the danger, the whole status of the question has altered. My own standard is this:

Are the organs diseased? Will their removal cure the patient entirely, or will it relieve a large part of the suffering and at least make life more bearable? A result *absolutely* good is always to be desired; but a result *relatively* good is something to be very thankful for, and grasped in many cases. Not only the general profession, but gynecologists themselves are apt to place all hope upon the operation, like a throw of dice, and to forget that it is often more rational to handle the cases from the beginning of their treatment to the end, in such a manner that the operation is viewed by doctor and patient as simply a *step*, at times the only one, again the most important step, or occasionally but one in the flight, in the treatment and progress toward cure.

Cases often require after-treatment, and

some of my patients have only left me entirely well after weeks more of work. My operation removed, it is true, the focus of the disease, without which I could never have made any progress, but my after-treatment dealt with the disease products which may have been accumulating for years, the embers, ever freshly kindling so long as the diseased tube and ovary remain, but now readily yielding to treatment. In other cases, I have been actually obliged to deal with disease of my own creating, for in three cases I have treated the women for cellulitic deposits formed, I believe, around the ligature at the stump.

Since my return from Europe, on Sept. 7, 1887, I have operated upon fourteen cases of abdominal tumors, including hysterectomy and pyo-salpinx. The last case is too recent to speak of, but not one of the others developed any fever after the operation, owing to my careful attention to the principles of antisepsis. A neglect of antiseptic precautions is criminal in any form of surgery. But this may be carried out with nothing but soap and water. The development of an antiseptic conscience is the chief point.

Dr. Dudley, of Chicago, uses a knot of his own invention, which I like best of all for most of these cases. It is made by entering the needle, with a double ligature, through the broad ligament, carrying it across, and reintroducing, bringing it out on the same side on which it entered. The needle is removed and the loop carried over the whole mass to be tied off and laid between the free ends of the ligature. This is grasped in the thumb and fingers and drawn up tight, then one end is handed to an assistant while the other is pulled tight; and next the other end treated in the same way, and in the same manner it is tied.

MEDICAL SCIENCE.

BY GEORGE J. ZIEGLER, M.D.,
PHILADELPHIA.

If physicians generally would have the following or something similar published in the secular press everywhere, they would greatly help to educate the people and diminish quackery of all kinds.

There appears to be great misapprehension respecting the character and the scope of medical science. It does not consist of a single *pathy* or *ism*, or of many shreds of *pathies* and *isms*, but of all truth pertaining to health and disease in their most extended relations. Hence, *pathies* and *isms* do not represent, and have no place therein, while the real knowledge and truth included in every *pathy* or *ism* belong to the general science of medicine, which is thus of universal compass. The application of the term Allopathy to legitimate medicine is a misnomer, and savors of quackery; while that of Allopathist, applied to the the regular physician, is justly repudiated as expressive of a reproach. The only term ending in *pathy* at all applicable to the science of medicine is *Anti*-pathy, or antagonism to all disease; but even this is too limited and misleading as to its nature and extent, as it only includes the mere prevention and treatment of disease, and omits all the collateral branches of biological and many of surgical science. This law of antagonism and principle of counteraction applies to curative medicine, as it is uniform and universal, and does not admit of any exceptions, much less of such as are implied in the sophistical dogma "*similia similibus curantur*," or like cures like, of homœopathy. The dictum that to cure one disease it is necessary to produce another of the same kind or similar to the one existing, and then that this like, stronger, and conquering disease gets well of itself, is a sheer assumption. The victim of one disease does not want, and should not be afflicted with another disease of any kind whatever, whether the the same (isopathic), similar (homœopathic), or dissimilar (allopathic), but wants to get well in the most direct way as easily and as speedily as possible. This it is the object of scientific physicians to accomplish by the most appropriate physical, mental, and moral means which can be brought to bear upon the case by this law of antagonism with counteracting and antipathic agencies, of which mere drugs of themselves are often of minor importance, though generally useful and frequently indispensable. The basis of medication is generally alimentation. This is often of itself sufficient to cure as well as prevent disease. The regulation of the diet, with the other hygienic measures of pure air, light, heat, clothing, rest, exercise, mental and moral conditions, etc., according to circumstances, being also necessarily in union with this system of counteraction or antipathy, or prevention of disease, this law of antagonism prevails, and *anti*-pathists adopt such measures as are counteractive to the disease, and as tend to restore the equilibrium of health. Drugs are administered in every form, proportion, variety, and way, crude or refined, single or multiple, separate or combined, in small or large doses, and all are

employed as necessary to the case under treatment. Scientific physicians discard all exclusive dogmas, *pathies* and *isms*, as being too narrow and sometimes fallacious; but they counteract disease by the sound, common-sense law of antagonism or anti-pathy. This may not always save life, just as carbonic acid and water may not always save property from fire, yet they are specific therefore, nevertheless. The science of medicine is one and universal in its range and application, and at the same time it is progressive —new discoveries, new truths, new remedies, being constantly added in its onward course towards perfection.

Society Reports.

OBSTETRICAL SOCIETY OF PHILADELPHIA.

Meeting of Thursday, December 8, 1887.

Thomas M. Drysdale, M.D., in the chair.

Dr. W. Goodell read a paper on

Intra-Ligamentary Cyst.

In it he stated that the three abdominal cysts most commonly met with are the true ovarian, the common parovarian and the intra-ligamentary cysts.

The ovarian is typically multilocular, has a pedicle, and starts from the stroma of the ovary, when the ovary is found. It always grows into the peritoneal cavity, and is probably due to a follicular degeneration of the ovisacs, which explains its multilocular feature.

The common variety of so-called parovarian cyst is typically unilocular, usually unadherent and thin walled. It does not bear inside papillary growths, but it contains a clear limpid fluid. It is wholly extra-ovarian, the corresponding ovary being found either pendant apart from it, or else plastered upon its walls, but yet wholly distinct. The lining membrane of this cyst being identical with that of the tubes of the parovarium, its origin is referred by pathologists to this fœtal relic. To account for its single chamber, it is supposed to originate from some detached loop of the tubes, or especially from a little cyst always found at the outer end of the horizontal tube of the parovarium.

The third variety of cyst is called the intra-ligamentary, senile, or encapsulated cyst. From its site between the folds of the broad ligament, from its papillary ingrowths and its quasi-malignant nature, and also from the difficulties attending its extirpation, it deserves special description, and needs a special treatment.

There are two kinds of cysts encapsulated by broad ligament. The one is a unilocular papillomatous cyst; the other a multilocular papillomatous cyst. Both contain clear fluid. The former is probably a cystic degeneration of one of the imbedded vertical tubes of the parovarium, which represents the rudimentary sexual remnants of the Wolffian body. It is usually more encapsulated by the broad ligament than the multilocular variety, but the connective tissue is looser and less vascular.

The multilocular intra-ligamentary cyst has but a few daughter-cysts, each cyst distended by a clear, limpid fluid and containing exuberant firm papillomatous growths. Its proneness to ingraft itself upon migratory organs and its firm and vascular union to its capsule of broad ligament make its removal far more difficult than that of the unilocular variety. Its origin is questionable, although the presence of papillary ingrowths would point to fœtal tubular relics as the source. Some attribute it to cystic degeneration of supplemental ovarian tissue often found imbedded in the broad ligament at a distance from the ovary. Others refer it to the tubular relics in the par-oöphoron. Lastly, Doron attributes it to stray fœtal relics in the hilum of the ovary. As this theory met every characteristic of this tumor, viz., the papillary ingrowth, its multilocular character and its investment of broad ligament, Dr. Goodell was inclined to accept it. The tumor did not develop in the peritoneal cavity, but growing inwards and into the broad ligament, it parted asunder the two peritoneal folds of the latter. As it burrowed upward it stripped off the peritoneal coat of the womb and bladder, fusing itself with these now naked organs by continuity of structure, and not by mere contiguity. Hence, in the operation for its removal, the womb was liable to be badly wounded and the bladder torn open. Burrowing downwards, it uncovered and soldered itself to the ureters, the great pelvic vessels and the rectum, making its separation here very dangerous and sometimes impossible. Mounting upward from this region, the sac goes in between the two folds of the mesentery, meso-colon and meso-cæcum, and, prying them apart, ingrafts itself upon these viscera. In these cases, a portion of the cyst must be left behind, as the union is too integral to be severed. Another characteristic is the proneness of the

cyst wall to burst and to infect the whole peritoneal cavity with papillomatous poison. Whether this is always malignant is doubtful, for he had seen patients wholly recover whose entire peritoneal cavity was studded with papillary growths. On the other hand, he had had them die in a few months after the operation.

The signs of an intra-ligamentary cyst are immobility and low descent of the sac, vertical elongation of the womb and bladder, embarassment in micturition and in defecation, pelvic pains, unsymmetrical abdominal development, and resonance on percussion from bowels carried up in front.

The operation for the removal of an intra-ligamentary cyst demands great experience on the part of the physician, and taxes all his pluck. These are the cases which are liable to die either on the table or a few hours afterwards from shock. Formerly, when a cyst was found to be intra-ligamentary, the incision was closed and the case abandoned. Now, thanks to Miner, of Buffalo, the surgeon need rarely be foiled.

Since the bladder is often dragged upward and then lies directly under the line of the incision, great care must be taken not to wound it. The cyst should then be emptied, but it must not be lessened in size by the introduction of the hand and the breaking up of daughter-cysts, because the flow of blood would be too great, and papillomatous material might escape into the abdominal cavity. For the latter reason the opening made by the trocar should be securely closed. The collapsed sac is now drawn out of the abdomen and the capsule is divided, little by little, in a circle on a level with the edge of the abdominal incision. The sac wall is then enucleated so as to leave an uninjured cup-like cavity. To do this with the least amount of hemorrhage, the incision should begin at the lateral border of the sac where the spermatic vessels lie. After these are secured, the incision is extended to the site of the womb, where will be found the uterine arteries, which will also be cut and secured either by ligature or by pressure forceps. As the surgeon advances he will have to tie or clamp many blood vessels. The attachment to the womb is left for the last, and it can then usually be brought outside of the abdomen, when it may be often converted into a sort of pedunculated attachment which can be ligated *en masse*. Often the whole sac is shelled out of its capsular nest, without any approach to a pedicle. In the deep portion of the enucleation great care must be taken not to injure the ureters, rectum or the large pelvic vessels. When firm adhesions to important viscera are met with, the adherent portion of the sac must be cut off and left behind, but its secreting layer should be peeled off.

The vast cavity of the empty capsule is treated in one of the following ways, each aiming to exclude it from the peritoneal cavity: (*a*) The edges of the capsular cup are attached to the border of the abdominal incision and a drainage tube is put in. (*b*) Through the flow of the intra-ligamentary wound a catch-forceps is thrust through into the vagina. There it is made to seize a winged rubber drainage-tube, which is drawn up into the capsular cavity. The edges of the capsule are now trimmed and sewn with gut, the one to the other so as to exclude its cavity from that of the peritoneum.

Whenever neither of these modes can be adopted, one large drainage-tube or even two of them should be introduced into the pelvic cavity.

Dr. Drysdale remarked that the paper of Dr. Goodell covered the ground so thoroughly that he could add but little to what had been said. One important point is the extreme thinness of the cyst wall, often met with in these cases, which in his experience had made it almost impossible to get the cyst away without tearing. Another difficulty, peculiar to this form of tumor, was the risk of wounding the great blood vessels of the pelvis when the cyst had burrowed under or became incorporated with them.

Dr. Drysdale understood Dr. Goodell to say that he believed that all operators in removing these tumors had met with the accident of opening the bladder. He was glad to say that in an experience of twenty-six years, he had never been so unfortunate as to open that organ.

Dr. Drysdale believed that true papillomata always proves fatal. The faith of some writers, in the occasional curability of these growths, is founded upon the error of mistaking a benign growth, which resembles them, for true malignant papillomata. These innocent masses of papillary granulations, in fact, so closely resemble the malignant that the microscope alone can distinguish one from the other.

Dr. J. Price has not had experience in the removal of this form of abdominal growth. He is pleased with the free use Dr. Goodell makes of drainage tubes; he himself has used three at one time in complicated operations. He is wishing for some form of perfected continuous irrigation applicable to the after-treatment of abdominal section. He has had

his greatest experience in removal of pustubes, and has met with a mixed ovarian and parovarian growth in many of his patients. Mr. Tait had described two varieties of papillomatous cysts, one having virulent characters and the other benign.

Dr. Goodell, in closing the discussion, said that his experience tallies with that of Dr. Kelly, that some of his patients were eventually poisoned by the virulent character of the cyst-contents, and died a few months later; while the majority were not affected at all. One explanation of these varying results may be expressed in the statement of Virchow that a papillary growth may be benign at an early stage of its development, and may afterwards take on malignancy. The walls of these parovarian, intraligamentary cysts are very thin, as mentioned by Dr. Drysdale. He had called attention in his paper to the danger of wounding the great vessels, and mentioned a case in his own practice, which Dr. Drysdale overlooked. He likes Monsel's solution as an application to oozing surfaces. He has used it freely, in full strength, over the whole capsular cavity, by means of a sponge saturated and squeezed out; or he wets the end of his finger with it and applies it to bleeding points. Our President has been very fortunate not to have wounded the bladder in such operations, for all the eminent operators have reported cases.

Dr. Goodell, speaking on

Resuscitation of Asphyxiated New-born Children,

said that he thought the danger in many of the methods advocated lay in their roughness; they were liable to put out the flickering flame of life. He had seen buttock-slapping and various other violent methods resorted to, to quicken slow breathing, and he was sure that they had extinguished the feeble life of the child. When the child gasps he sometimes blows on the chest, or gently rubs its back, to induce more frequent respiration, and then lets it alone, merely wrapping it up warmly. But if there should be no effort at respiration, and the heart still beats, then any of these rougher methods are permissible. In the Preston Retreat he was accustomed to lay the child across his hand, the head and arms hanging down on one side and the limbs on the other side of the hand; then he gave it a quick upward movement, and, as it came down, he doubled the child up, with its knees to its chin. This folding and unfolding of the child favored the entrance and exit of air. But after it had gasped once he stopped all violent movements and practically let it alone. In one case, where he had been called in, in consultation, one of tedious labor, the child of a physician, after all efforts had been made to induce respiration, they were discontinued as fruitless, and the child was laid aside as dead. In a few minutes afterwards it was heard to cry, and is now living. In another case, after every method of inducing respiration had failed, the child was pronounced dead by the father, a physician, and also by the attending physician. To keep the body sweet it was placed outside of the window on the roof, the night being a cold one. When the child was taken in to be washed before it was laid out, it was found living, and it is now alive. On one occasion, at the Preston Retreat, a child was laid aside in a corner as dead, after he (Dr. Goodell) had used various methods of artificial respiration. An hour later the nurse took it into the bath-room to wash its body, and she found it breathing. It, also, lived.

Dr. Longaker wished to emphasize the principle of not doing too much to quicken respiration. He feels sure that one child would have had a better chance for its life if he had not inserted a catheter into its trachea. He succeeded in making the child breathe, but the air vesicles were injured by over-distension, and death resulted twenty-four hours later. Rubbing the back is a very good method. Dr. Champneys, in the *Amer. Journ. Med. Science*, April, 1886, recommends holding the child with its head in a dependent position, to relieve anemia of the medulla, which he thought the cause of asphyxia in many cases.

BALTIMORE ACADEMY OF MEDICINE.

Regular Meeting, Dec. 20, 1887.

A Case of Aneurism of the Terminal Branches of the Auricular Artery.

Dr. Hiram Woods presented a case of a colored boy, 17 years old, with an aneurism of the terminal branches of the auricular artery. When he was 7 years old his mother noticed a little lump on the front of the ear and another small lump about as big as a pea on his neck. These lumps gave no pain and did not seem to grow for a long time. About three years ago they began to get larger and gave pain. The mother pricked the one on the ear with a pin, when it bled and became empty, but filled up again soon. She repeated this operation several times with the same result. The lump on the neck was

scraped open and bled for a long time. When Dr. Woods examined the patient he found that the tumor on the ear pulsated, collapsed on pressure and filled up again when pressure was removed. Pressure on the carotid artery stopped it. It was seen that three or four branches supplied this aneurism, and when compression was exercised on both the anterior and posterior auricular arteries, pulsation in the aneurism ceased entirely; but when only one of the above-named branches was compressed the pulsation was lessened but not entirely stopped. In looking into the literature of the subject he found that Buck had never seen a case himself, but recorded several others. One was a cirsoid aneurism in which the persulphate of iron had been used. In another case the tumor was large and the hemorrhage profuse. Ligation of the external carotid was performed. A third case reported by Kipp, of Newark, was attributed to a blow. It was the only case he could find which had followed an injury. Roosa mentions a case of Gruenings which was almost a duplicate of the case presented by Dr. Woods. In this case a subcutaneous ligature of the arteries was done. Politzer and others have reported cases which were treated in various ways:

1. By passing through the tumor threads saturated with iron. He considered injections of iron dangerous. 2. Ligation of the arteries and scraping the sac. 3. By using thermo-puncture. In his case he had passed a needle armed with a thread under the arterial branches, and found that the pulsation had almost disappeared, although the threads had not been tied. The subsequent treatment was to ligate the vessel and scrape out the sac.

Dr. J. J. Chisolm thought it was very curious to see that the pressure of the thread had almost arrested pulsation before it was tied.

A Case of Intussusception.

The President, Dr. W. C. Van Bibber, then presented an interesting specimen of intussusception of the ileum with the following history. The patient, a woman, who lived in the country, was taken with pains in the right iliac region, and at times these pains were violent. She was for five days under a local physician who gave purgatives, enemas and anodynes with only temporary relief. On the sixth day after a hot rough ride from the country, she came under Dr. Van Bibber's care. He found her in violent pain, and felt a large hard tumor in the right iliac region. There was also sensitiveness over the whole abdomen. She said there was no hemorrhage from the bowels and no evacuation from the bowels for several days. He had twelve leeches applied and gave purgatives, and later found that the tumor had almost disappeared. He thought this was singular and made an examination by the rectum and vagina, and found the tumor deeper down. She had pains after this and soon vomiting, which was, however, not stercoraceous. She grew alternately better and worse, and finally sank into a collapse and died. The autopsy, thirty-six hours after death, showed nothing abnormal in the abdominal cavity, except in the portion involving the parts contiguous to the ileo-cæcal valve. There was also a slight general peritonitis, most intense near the point of lesion. The condition of intussusception had been recognized some time before death, but after consultation with Dr. L. McLane Tiffany and Dr. Claude Van Bibber he considered an operation not advisable.

Dr. Wm. H. Welch, at the request of Dr. Van Bibber, demonstrated the specimen. He said that the most common situation for intussusception in the adult is the lower part of the ileum. In this case the intussusception, which is descending, extends to within five inches of the ileo-cæcal valve, the whole part intussuscepted being ten inches in length. The specimen shows well the anatomical relations of intestinal insusception, viz.: the entering or internal layer, the returning or middle layer (the two constituting the intussusceptum), and the receiving or external layer or sheath, this being the intussuscipiens. In consequence of the disturbance of circulation due to the displacement of the mesentery there are œdema and hermorrhagic infiltration of the intussuscepted intestine, particularly of the lower seven inches. The entering intestine is much contracted and filled with blood; between the entering and the returning layers (serous surfaces in contact) there is a mass of clotted blood, and between the returning and the receiving layers (mucous surfaces in contact) there is bloody mucous. The intestinal walls are hemorrhagic, in fact the condition is that of a genuine hemorrhagic infarction of the lower two-thirds of the intussusception.

The most interesting feature of the case is its causation. In the entering layer, about three inches from the top of the intussusception, is a polypus, somewhat larger than a pigeon's egg, which, on microscopical examination, is found to be composed of dense fibrous tissue infiltrated with blood. It is attached by a broad pedicle. The curious thing is that the polypus is not situated at

the lower extremity of the intussusception.

According to Leichtenstern's statistics, which are the most complete we possess, a polypus has been found in thirty out of about six hundred cases of intussusception. Brinton reached the same result by the analysis of his statistics (a polypus in five per cent. of the cases). Medical literature is full of reports of intussusception depending upon polypus. It can hardly be doubted, therefore, that a connection exists between polypus and the production of intussusception; and it has generally been considered that the mechanism by which the intussusception is produced is more readily understood in the cases with polypus than in other cases. The accepted and apparently correct explanation is that the polypus by its weight draws down the part of the intestine to which it is attached and invaginates it. One would naturally expect, in such a case, the polypus to be at the lower extremity of the intussusception; but, in the present case, the polypus is found, not at the lower end, but near the top of the entering layer of intestine. How is this to be explained? If we regard the polypus as in any way concerned in the production of the intussusception,—and one would certainly be unwilling to reject a causative factor so manifest,—an explanation of the manner in which the intussusception was produced in the present case may be deduced from the interesting results obtained by Nothnagel in his experimental work on intussusception. Nothnagel aims first to test the two prevalent theories concerning the causation of intussusception: one theory being, that the intussusception is due to a spasmodic contraction of a part of the intestine, the contracted part becoming invaginated into the adjacent intestine, either above or below; the other theory being that intussusception is referable to paralysis of part of the intestine. Nothnagel's experiments were made upon rabbits placed in a bath of warmed physiological salt solution, the intestines being allowed to float out into this solution, in which it has been shown that the conditions of normal peristalsis are not much disturbed. Nothnagel was unable to obtain any experimental support for the paralytic theory of intussusception, but he was able to produce intussusception by causing spasmodic contraction of a part of the intestine. By applying the electrodes of a Faradic battery to the intestinal wall he was able to cause a firm circular contraction of the intestine at the seat of application. If the electric current was strong, this contraction extended a considerable distance upward, but only a short distance downward. In a large number of cases Nothnagel observed that a descending intussusception was produced, beginning just below the point of application of the electrodes. Within one or two minutes as much as four inches of intestine might become invaginated. The intussusception grew in length, however, not at the expense of the intestine above the entering layer, but at the expense of the receiving layer. By marking a point on the entering layer at the neck of the intussusception, Nothnagel found that this did not descend or change its relations. On the other hand, by marking a point on the receiving layer he observed that this was gradually drawn upward, apparently by a contraction of the longitudinal muscular coat, and after passing over the bend joining the returning and receiving layers this point descended into the returning layer. In this way the intussusception grew by the receiving layer being gradually drawn over into the returning layer, and the latter in turn being transformed into the entering layer. This explanation of the possible production of intestinal intussusception is contrary to the generally accepted views, but it is supported by the relations of the polypus present in Dr. Van Bibber's case; in fact this case may be regarded as a most important contribution to our knowledge of the manner in which intussusception may be produced.

It is apparent from the examination of this specimen that if laparotomy had been performed, and the intestine in its present condition had been replaced, that it would certainly have undergone necrosis. The only practicable operation when the intestine is the seat of an intense hemorrhagic infarction, as in the present instance, would be the resection of the entire intussuscepted intestine.

In opening the discussion, Dr. James Carey Thomas, on observing the thickness of the intestinal walls, in the specimen exhibited, asked if this hypertrophy was not very great for the short time.

Dr. Wm. H. Welch thought that the history of this case showed that this condition of intussusception had been going on for some time.

Dr. Christopher Johnson mentioned a case of his own, of a woman with violent pains and frequent vomiting, and from whom thirty inches of the small intestine were passed by the bowel, and the patient recovered.

Dr. Wm. H. Welch said such cases had been observed. Peaslee reported a patient who passed five feet of intestine, and Cruveil-

hier reported a smiliar case in which over nine feet of intestine had been passed.

Dr. A. K. Bond thought that the manner of invagination and the relation of the different layers could be partially explained by the difference of friction between the serous and mucous surfaces.

Dr. Wm. H. Welch thought that the matter of friction could be entirely left out, as the difference was scarcely appreciable in the causation of intussusception. He said that it was very common to find a condition of intussusception at the autopsy when there had been no suspicion of it in life, but the absence of inflammation showed that the invagination had occurred at the time of death, probably during the death agony.

Dr. W. C. Van Bibber, in closing the discussion, spoke of the repeated attacks of colic in his case and of the diagnosis of intussusception before death. He also spoke of Dr. Warren's (of Boston) experiments of taking out part of the intestine of a dog and allowing the animal to recover.

Dr. James Carey Thomas then reported a case of

Pneumonia Presenting Unusual Symptoms.

A man, aged 47, was worried and anxious on account of his business and had been complaining for some time. He fainted once in a Russian bath and struck his shoulder, bruising it. He went on ailing and feeling badly. His wife noticed that he had fever, and the week following he showed symptoms of typhoid fever. He had no diarrhœa, no pain over his lungs, no expectoration and little or no cough. All his uneasiness was situated at the pit of the stomach. He had had typhoid fever ten years before and this was probably not a second attack, although his previous attack had commenced in the same way. On the second or third day some crepitation was discovered in the right lung and the whole lung became solid. Eight days after, there was defervescence and the patient was very faint. The temperature was normal. Three days later a pneumonic trouble was found in the left lung. Later he did well, had no fever, pulse was normal and respiration 20, and he had a good appetite. On Sunday he took a cold bath, which brought on a pleurisy. The interesting points about the case were consolidation with crepitation and absence of pain, cough and expectoration. In reply to Dr. William B. Canfield he said that in both lungs the normal vesicular murmur could be now heard.

Hospital Notes.

Pennsylvania Hospital.

(Service of Dr. James H. Hutchinson.)

Pleurisy with Effusion; Differential Diagnosis; Indications for Tapping.

At his clinic at the Pennsylvania Hospital, Wednesday, Jan. 4, Dr. Hutchinson reviewed the history of a case of acute right-sided pleurisy with large serous effusion, occurring in a lad nine years old. The attack had followed exposure, and its onset was violent —the chill being severe and prolonged, and the temperature reaching 104.5°. The subsequent effusion was of such quantity that only a limited portion of the apex of the lung remained in contact with the chest walls. In speaking of the differential diagnosis of this disease from pneumonia, the following points were emphasized as being of special value: the shifting of the line of dulness occurring in pleuritic effusions with each change of the patient's posture; the absence in this disease of vocal fremitus and resonance, while, in pneumonia, they are increased; the marked alteration in the latter disease of the normal pulse-respiration ratio; and, finally, the dislocation of the neighboring organs produced by large effusions, pneumonia not being marked by such changes. Concerning the treatment of cases such as this, antiphlogistic measures were regarded as of value during the stage of invasion—cupping the affected side, exhibition of antimonials, etc. Reference was also made to the "dry" treatment, which might be adopted at a little later period of the disease, when the effusion of serum is about commencing. This is a favorite plan of treatment of Dr. Osler, of the University of Pennsylvania, and consists in the restriction of the quantity of fluid received by the patient to the smallest possible proportion, and in the administration, at the same time, of saline cathartics, with a view of carrying off by the intestinal tract a large quantity of fluid that would otherwise be effused into the pleural sac. Dr. Hutchinson cautioned his hearers against pushing this plan of treatment to the extent of seriously weakening their patients.

In cases where, in spite of restraining measures, large pleural effusions have occurred, the lecturer deprecated the adoption of tapping as a routine method of getting rid of them. He said that in his experience the operation was followed in the majority of cases by a return of the fluid, and that,

whereas it may have been serous before the tapping, it was apt to become purulent after it. He, therefore, considered the measure as justifiable only under the following conditions: First, when the effusion is so rapid and large, and respiration is so seriously embarrassed in consequence, that any delay in affording relief would endanger the life of the patient; second, when the effusion has become purulent in character, or, in other words, has become an empyema; third, when, after a reasonable period spent in endeavoring to procure absorption by the administration of appropriate remedies, the effusion shows no disposition to disappear.

Should it be determined to resort to this operation, the effusion being *serous*, Dr. Hutchinson advocates the use of the aspirator. When, however, an *empyema* exists, he recommends the making of a free incision and the insertion of a fenestrated tube of sufficient calibre to insure free and complete drainage. In support of this view, he cites a case, now in the hospital, which was rapidly convalescing with most satisfactory results from an operation of this kind.

Emphysema with Mitral Insufficiency.

The patient was a woman, aged fifty-eight. She was brought to the house several days before gasping for breath, deeply cyanosed, and with a frequent hacking cough. There was a history of exposure to wet and cold, soon followed by cough and dyspnœa. Physical examination revealed an emphysematous condition of the lungs, bronchial tubes choked with mucus, and a mitral regurgitant murmur at apex of heart. This latter lesion was a result of the long standing obstruction to the free flow of blood through the lungs. The cyanosis was produced by the sudden excess and accumulation of secretion in the bronchial tubes and the consequent inadequate oxygenation of the blood. Carbonate of ammonia had been given in five grain doses every two hours in combination with digitalis, and this treatment had effected a marked amelioration of the woman's more distressing symptoms. In closing, the lecturer said that he regarded digitalis as far superior to any of the drugs that had been recently introduced as substitutes for it. He did not consider strophanthus, adonidine, or convallaria, as at all comparable to it, either in power or rapidity of action.

—A supposed case of leprosy, at Atlanta, has been reported to the Illinois Board of Health. A physician has been sent to Atlanta to investigate.

Periscope.

Ustilago Maydis as an Oxytocic.

Dr. W. A. N. Dorland, of the Philadelphia Hospital, after a study of ustilago maydis, summarizes his results as follows in the *Medical News*, Nov. 5, 1887:

1. *The toxicology and physiological action of the drug.*—No cases of poisoning in man by the drug are on record. That it is, however, possessed of toxic properties in large doses has been proved by Mitchell. He found that in the lower animals, in large doses, it acted violently upon the spinal cord, paralyzing first the sensory, later the motor tracts; finally involving the motor, and probably also the sensory nerves. Like ergot, then, it is probable that the chief force of the drug, in toxic doses, is expended upon the nerve centres, producing a toxic paralysis.

The action of ustilago upon the uterus has been more carefully noted. After the ingestion of a sufficient amount, in from twenty minutes to half an hour, the pains, if present, are increased in severity, in frequency, and in duration, presenting a marked *clonic* character, following each other in frequent succession, with a decided intermission between each. In this respect it differs decidedly from the action of ergot, which, in full doses, produces one continuous, *tonic* spasm of the uterine muscle. It is this property of ergot which has, when administered before the delivery of the placenta, produced in so many instances the irregular contractions of the uterus, of which the hour-glass is a well known example. The employment of ustilago seems to be entirely free from such unpleasant complications. In addition to being a valuable adjuvant to stimulating weak uterine contractions, ustilago seems to possess the property which some years ago was ascribed to quinine: namely, that of exciting uterine pains when these were entirely suspended.

As to the time required for the action of the drug to become apparent, it may be said that it differs in different cases, depending undoubtedly upon the rapidity with which it is absorbed from the gastro-intestinal tract and carried into the system. In only two instances did it require over thirty-five minutes before the ustilago acted upon the uterine tissues, and in one case most of the drug was ejected by emesis. In the remaining seven cases the average time required was twenty-five minutes.

The effect produced by ustilago upon the other unstriped muscular tissues of the

body has not been inquired into. Probably it produces the same increase of intestinal peristalsis, and the same rise in the arterial pressure due to vaso-motor spasm, as is produced by ergot. This is yet open to investigation.

2. *The indications for the employment of the drug.*—The author considers the first indication for its use to be the failure of the pains, with *complete dilatation of the os uteri.* In none of the cases was the drug employed until the pains of labor had either become so weak that they were inefficient to accomplish the expulsion of the fœtus, or until they were entirely suspended. The second indication for its use is the *inefficiency or entire suspension of the parturient pain.* After the ustilago had been taken, it may also be noted that in no case was there the slightest tendency toward a post-partum hemorrhage. In each case, after the expulsion of the placenta, the uterus remained in a state of firm contraction. While during the three months the great majority of the remaining cases, in which the customary ergot had been employed, showed no tendenry whatever toward this alarming accident, in two instances, however, was there such an occurrence demanding prompt attention. The third indication, then, for the employment of ustilago is *a condition of uterine inertia threatening or producing post-partum hemorrhage.*

3. *The dose and mode of administration.*—The preparation of ustilago employed in all reported cases, as well as in his own, was a good fluid extract. The dose of this varies from one-half to two drachms, one drachm being a fair average. This may be repeated at intervals as required. If necessary, it may be used hypodermically in doses of from five to fifteen minims.

The author states that the advantages of ustilago over ergot are (1) that it does not produce irregular contractions, with all the consequent complications and sequelæ; (2) containing but 2½ per cent. of fixed oil, while ergot contains from 25 per cent. to 28 per cent., the dangers of absorption are reduced to a minimum; and, finally, (3) as it can be procured at a cost of 50 per cent. less than that of ergot, it seems to be in a fair way toward supplanting the latter in obstetrical practice, should the results of the investigations thus far be confirmed hy subsequent researches.

—The Marine Hospital Bureau is informed that cholera prevails in Santiago and Valparaiso, and that Peru has established a quarantine against nearly all the Chilian ports.

Suction in the Removal of Foreign Bodies from the Bladder.

Reginald Harrison, F.R.C.S., says in the *Lancet*, October 29, 1887, that the chief difficulty connected with the use of the lithotrite for elongated bodies is the fact that the foreign body is invariably seized at right angles with its long axis. He has, therefore, discarded the lithotrite as an extractor, and trusted to a large-eyed evacuating catheter, such as he uses for lithotrity, and a rubber wash-bottle connected with it, by means of which he can fill and empty the bladder with a stream of water of considerable force. When it is remembered that most foreign bodies introduced into the bladder are of an elongated nature before they become nuclei for stony concretions, this method of removing them at once commends itself. If a rubber bottle is attached and a stream of water is forced into and out of the bladder, it will be found, as a rule, that the end of the foreign body is sucked into the catheter, and in this way may be withdrawn.

One of his recent cases, he says, was a curious one, and was seen in consultation. A middle-aged healthy man a month before the consultion passed a piece of bacon rind about two inches in length up his urethra; this disappeared. He introduced a week afterwards, up the same canal, a stiff pigs's bristle about five inches in length, which also disappeared. Ten days before Mr. Harrison saw him he felt a severe pricking sensation, and at once confessed his indiscretions to his medical adviser. Dr. Harrison passed a soft instrument down his urethra, and distinctly felt something in the prostatic urethra. He then passed a large-eyed evacuating catheter into the bladder, and attached a powerful rubber syringe to it, such as he uses for the removal of stone fragments after lithotrity. After a few movements of the syringe he felt that he had engaged something in the eye of the catheter, and on withdrawing the latter, the bristle, beautifully coated with phosphates, came with it. Of the bacon rind he neither felt nor heard anything more. These manœuvres were quite easily carried out on the author's consulting-room sofa without an anæsthetic. Some weeks previously he had removed a piece of gum-elastic bougie (No. 6), three inches in length, in the same way. To commence with, he felt, as the water current was being injected, the bougie strike against the eye of the catheter with its long axis, and was therefore not caught. He then distended the bladder with another syringful of water (four ounces), when at once the end of the bougie became impacted in the eye of

the evacuating catheter, and was withdrawn like the bristle. The additional amount of water permitted the bougie to rotate in the bladder. Still more recently, by the same process, he dislodged a renal calculus which he believes was impacted in the orifice of one of the ureters, where for some weeks it had caused much irritation.

Baths in Childhood.

Calatraveno, in a paper on this subject in *El Progress Ginecologico*, July 10, 1887, says: The great importance of bathing establishments in the treatment of disease in adults has long been recognized, but the principle has not been applied to any great extent in the treatment of disease in children. In view of the great number of children who are affected with chronic diseases, especially scrofula and tuberculosis, and the eminent advantages which are to be obtained by the systematic use of water, the author makes a plea for its more extended use. Children with these diseases should be removed to a station by the sea-shore, where the constant inhalation of the pure atmosphere will serve as a powerful tonic. The beneficial effect of playing in the warm sand must not be overlooked. If the child is feeble and the water cool it should not be used more than five minutes at a time, whether by pouring, sponging or immersion. Small quantities of sea-water may also be drunk with advantage with each bath. Of course the child should not be bathed while the body is warm, nor within three hours after the last meal. Currents of air should be avoided during and after the bath, and the child should be encouraged to take some exercise immediately after being dressed. Of the medicinal waters which are of service in the treatment of scrofula, the sulphur waters of all kinds are effective, but those containing sodium-chloride are more so. For the poor who cannot go either to a mineral spring or to the sea-shore, hygienic treatment at home is quite possible, artificial salt or sulphurous water being readily and cheaply obtained, and home treatment by rubbing and douching being also possible. For children from one to three years of age the temperature of the bath should be 60° F. to 68° F., and the back, arms and legs should be briskly rubbed every day. From six to ten years of age the rubbing should be general, and the duration and frequency of the baths or douches regulated by the resisting power of the patient. If sulphur baths are indicated, a few grains of sulphate of potash added to the water of the bath will procure the desired condition. If such means of treatment were more generally adopted with scrofulous children there would be fewer developments of phthisis among them, and a more robust condition of health in general.—*Archives of Pediatrics*, December, 1887.

The Use of Fats and Fatty Acids in Chronic Wasting Diseases.

Senator has a paper on this subject in the *Centralblatt für Kinderheilkunde*, Sept. 3, 1887, which is abstracted in the *Archives of Pediatrics*, December, 1887.

In chronic diseases, accompanied with great emaciation, the custom is to prevent loss of fat as much as possible, and also to administer fats, if they can be borne. The fat in ordinary nutriment will fulfil both these indications, while it acts also as a reserve supply, and tends to limit the albumen metamorphosis, and diminishes the disintegration of the albumen in the nutriment as well as in the body itself. Fluid fats, however, easily become intolerable, and especially is this the case with cod-liver oil. The author, therefore, has made use of the more solid fats in the treatment of these diseases, especially taking spermaceti, which was long ago used in the treatment of disease in children, and powdering it, administering it in teaspoonful doses, either alone or with the addition of three parts of sugar. After the use of fifteen to twenty grains of the spermaceti daily for some time no considerable quantity of fatty acids could be recovered from the fæces. A mixture of spermaceti and oil was also used in some experiments upon dogs, and only a portion of it could be recovered from the fæces; the remainder must have been digested and absorbed. Since fats are broken up in the intestine into fatty acids and glycerin, and the latter may undergo acid fermentation (which may partly account for the disturbances of digestion occurring after the use of fats), and since the fatty acids will have the same effect upon the tissues as fats themselves, it occurred to the author to have coated pills made, containing each four and a half grains of palmitin acid and two grains of oil acid, and these were well borne by the stomach. The author deemed it feasible to administer fats with alkalies,—that is, in the form of soap,—believing that the same effect upon the tissues would be produced as by the use of the fats alone. A portion of the fats ingested must be converted into soap in the intestine, and this labor might be saved by administering the soap *per se*. Coated pills were made for the author from medicinal soap dissolved in

gum. It was also given in the form of powder, with the addition of sugar or oil sugar, and could readily be taken in this form. Good results from this treatment were seen in diabetes, phthisis, chronic icterus, and cirrhosis of the liver, and no accidents occurred. It is desirable that, in addition to the soap, spermaceti and cod-liver oil should be given whenever possible.

A Sign of Live Birth in Certain Cases of Suspected Child Murder.

Dr. F. W. Higgins, in a communication to the *Med. Record*, Dec. 17, 1887, comments upon the well-known fact that one of the most difficult questions which the medical jurist is called upon to decide is that of live birth where foul play is suspected. The hydrostatic test is about the only one which is at all conclusive. By this test, properly performed, one may quite positively affirm whether respiration has or has not taken place. But while killing the child in utero is criminal, and killing it after birth is murder, there is no punishment if the child be killed before it has been completely born, even after respiration has been fully performed. Nor does there seem to be any test given, by any authority, by which one may determine whether the birth was complete when death was inflicted. With a view of helping to furnish such a test, he reports an examination of an infant, which collateral evidence showed was strangled at birth. The choking caused death, not so much by suffocation as by compression of the jugulars and hemorrhage at the base of the brain, and also by the condition found in the heart. The cord was cut off close to the body. Both cavities of the heart were found filled with dark, *frothy* blood. The conclusion arrived at was that compression had lessened the pulmonary circulation just as it was being established. The heart, still beating and unsupplied with blood, had *sucked* in air through the divided umbilical vein. Evidently, he concludes, this could have happened only after the body had come into the world and the cord, the last bond to the mother, had been severed.

A Case of Bilharzia Hæmatobia.

In the *Glasgow Medical Journal*, December, 1887, Dr. A. Napier reported the case of a man, 28 years old, who had enjoyed good health until he went to Egypt in February, 1882. In that country he seems to have enjoyed fair health for about eight months, when he had an attack of piles and internal fistula, ascribed to sleeping three nights in the desert. This was soon followed by his present ailment, the first indication of which was the discovery of a bright and red blood stain, of the size of a half-crown piece, on his shirt. Then daily, for two months, he lost a little blood, bright-red in color, and varying in amount from thirty to sixty drops with each act of urination, the blood coming at the end of the stream. When this had continued for two months, he was suddenly attacked with pain, dull or sub-acute in character, and radiating from a point in the middle of the lumbar region. With this began the passing of small shreddy clots or sloughs, along with the bright red blood. At the end of another month—that is to say, after three months' illness, urination was one day found to be impossible; distension of the bladder became very distressing, and at last, after many fruitless efforts and much hard pressure, a gelatinous clot came away. This was about an inch in length, one-half an inch in diameter, cylindrical in shape, and transparent or slightly milky, not unlike jelly. Similar but much smaller clots subsequently came away from time to time. His other symptoms, briefly stated, were great irritability of the bladder, and seminal emissions at first with each urination, subsequently only at night, and afterwards ceasing; emaciation; general debility; improvement, and a return to fair health, with general tonic treatment and a suitable change of climate; the persistence of the loss of blood, even if slight in amount, and the evidence of the continued presence of the parasite in the urinary apparatus, probably in the kidneys. The patient states that this form of disease is very prevalent in Egypt, and believe that about fifty per cent. of the inhabitants of Egypt living along the Sweet Water Canal suffer from it. This he ascribes to the foul canal water they have to drink.

Treatment by salicylate of soda was suggested by the patient, as a friend of his own, who was greatly exhausted by the disease, obtained much benefit from salicylic acid after the comparative failure of the usual climatic treatment. This patient is inclined to think that he was benefited to a slight extent by the salicylate of soda.

—At the meeting of the State Board of Health, at Lansing, Michigan, January 11, Professor Vaughan reported a successful experiment of producing in a cat a disease similar to typhoid fever in the human being, by the use of the germs found in the water used by the victims of this disease at Iron Mountain, Michigan.

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THE PHYSICIAN AND THE SURGEON.

We have received from one of our correspondents a very interesting communication upon the relative positions of the physician and the surgeon. The writer belongs to the former class, and seems to feel that some slight is put upon physicians by the popular applause awarded to surgeons. There can be no doubt that, as he says, the present age is one in which surgery is glorified. The very character of its operations is such as to attract public attention; and the boldness and safety with which organs, long deemed beyond the reach of surgical skill, are now cut into or cut out, excites a natural wonder at, and admiration of, the courage and success of those who practice surgery. It is true also that the work of the physician is usually less conspicuous than that of the surgeon, and that he often employs the highest order of intellect in labors which are performed in comparative obscurity. But we think it is a mistake to suppose that the community does not appreciate physicians as highly as it does surgeons. In our own country there are no names which have been more honored than those of Rush, Chapman, Wood and Flint, who have left us, or of Stillé, Da Costa and Weir Mitchell, who are yet with us.

But fame is not the highest reward for work well done; and, in estimating the opinions of the world upon those who practice the healing art, it must not be forgotten that physicians, as a class, have a much better opportunity than surgeons to secure the regard and affection of their patients. This is a fact which ought to compensate the former for the loss of some of the admiration which the latter secure, because their work and its results are more striking to the senses. The position occupied by thousands of men who practice medicine modestly and quietly, and whose names are never heralded to the world, is in our opinion one of the noblest to which a right-thinking man can aspire. To them the lives of their patients are daily entrusted; their profoundest secrets are confided; in them the deepest confidence is reposed; they often follow from birth to death the career of those who are under their care; and when their office is faithfully performed, no one in the community is more loved and honored than are they.

Surely such a reward leaves no room for envy; and those who enjoy it need never grudge the due meed of praise to those who labor in another part of the same field.

A FRENCHMAN'S VIEW OF MEDICAL EDUCATION IN THE UNITED STATES.

In several numbers of the *Bulletin Médical*, in December, 1887, DR. ARTHUR HUGENSCHMIDT, of Paris, who was recently graduated, first in dentistry and afterward in medicine, from the University of Pennsylvania, publishes an interesting series of papers on medical education in the United States. In these papers there is much which might instruct our own countrymen; for Dr. Hugenschmidt has studied his subject very thoroughly and presents it very clearly and tersely. He describes the regular schools of medicine, and their methods and standards of teaching, in a way which does ample justice to their different merits. He also gives a fair account of the eclectic and

homœopathic schools of the United States; and devotes some space to the women's medical colleges, paying a high tribute to their excellence, and especially to that of the Woman's Medical College of Philadelphia.

One of the best written parts of this series of papers is that in which the author describes the life of the medical student in America. This description includes an account of his habits of life and habits of study. The former he thinks pleasant, though trying to the digestion; the latter he thinks severe upon the mind and the body. Still, he thinks the intense application demanded of medical students in this country makes three years of study here equal to five or six years of study for most French medical students.

It is always interesting to see how the manners and customs of any country impress those who are not brought up to them, and it is usually possible to draw some lessons of profit from a sensible and amiable review of them by a foreigner. So the papers of Dr. Hugenschmidt may, if rightly considered, furnish something more than entertainment to us, on account of the generally complimentary tone in which they are written. Some of the defects in our system of medical education, which he points out, may be more easily remediable than we think, and it will be wise to heed his friendly criticisms.

THE PERIOD OF CONCEPTION.

A very important point to be borne in mind, in making a scientific estimate of the duration of pregnancy, is the fact that conception may occur very soon after a productive intercourse, or when an interval of some days has elapsed, or it may be even after an interval of one or two weeks.

We state this as a fact, because, although we do not feel sure that it cannot be disproved, we do feel sure that it is a reasonable inference from what is frequently observed. It is our conviction that the spermatozoa may maintain life for a comparatively long period in the body of a woman; that they may meet an ovum under circumstances favorable to its fecundation at any time in this long period; and that the determination of the time at which this coincidence may occur is more or less accidental. The menstrual epoch in woman differs materially from the period of heat, or rut, in the lower animals—being unfavorable to conception; and a fruitful coitus is usually one which occurs long enough before the menstrual molimen to lead to impregnation and a successful lodgment of the ovum, before the congestion and flux of this period threatens its vitality or breaks up its nidus.

The period at which impregnation occurs cannot be said to be that of the fruitful coitus; on the contrary, it is probably in most cases later than this by some days or weeks, and all calculation of the duration of pregnancy, based upon a different assumption, are likely to prove misleading.

WASHING OUT THE STOMACH IN CHILDREN.

At the last meeting of the German Congress of Naturalists and Physicians, at Wiesbaden, Dr. Lorey, of Frankfort, gave an account of forty-three cases of children, some as young as two years old, affected with dyspepsia, in which he practiced *lavage*, or washing out the stomach by means of an œsophageal tube. The indications for this operation seem to have been: fulness of the stomach and fetid breath. In the case of thirty of his little patients, Lorey says that from one to three washings with a weak solution of chloride of sodium cured their dyspepsia. He therefore recommends this plan of treatment for general adoption.

Such a recommendation is not likely to be followed in this country, where the introduction of a stomach-tube, for the cure of simple dyspepsia, in little children, would probably be regarded as an unpardonable brutality. If the advocates of this method were aware how much can be accomplished, in cases of overloaded stomach and fetid breath, with small and repeated doses of calomel, or even of naphthalin—not to say castor oil—we do not think he would be so cruel to his little patients as to force them to submit to washing out their stomachs.

PTOMAINES.

The proceedings of the German Medical Society of Philadelphia, which we published in the last number of the REPORTER, relate to a subject of great importance to all physicians. A large part of our knowledge in regard to the development of poisonous products by the decomposition of animal tissue in the intestinal canal is of comparatively recent date, and the significance of the words "ptomaine" and "leucomaine" is not yet thoroughly understood by the profession at large. Some of the details of the study of this subject involve abstruse biological and chemical questions; but, without following them up, it is desirable that some idea of what is now believed by those who have made special investigations in regard to them should be circulated as widely as possible.

The paper of Dr. Wolff was so full of detail that we thought it wise to condense it somewhat. In the discussion which followed it, our readers will find practical applications of the current theories in regard to ptomaines which will interest, and may profit them.

THE TREATMENT OF STERILITY.

The paper of DR. WEINTRAUB on sterility in Syrian women, which is published in this number of the REPORTER, contains, not only an interesting description of the effects of the condition in the East, but also a very useful and practical suggestion in regard to its proper treatment everywhere.

It is not so common in Europe or America for women to lament the fact that they are barren as it is in Oriental lands. The complaint here is usually that they are too prone, or too liable, to conceive. Still it does sometimes happen, even in our own land, that a husband or a wife will appeal to the physician for advice how to overcome the obstacles to conception. In such a case the suggestions of Dr. Weintraub, which bear the mark of sensible thought, and which have been carried out with so much success in her own practice, deserve to be carefully considered by the physician.

PAMPHLET NOTICES.

THE TRUE NATURE AND DEFINITION OF INSANITY. By C. H. HUGHES, M.D. From the *Alienist and Neurologist*, October, 1887. 30 pp.

THE CONFIDENCE OF THE PUBLIC IN NON-PROFESSIONAL PRESCRIPTIONS. By W. S. LEONARD, M.D. Manchester, N. H.: Printed by John B. Clarke, 1887. 17 pp.

IMBIBITION OF POISONS. By PROF. JOHN J. REESE, M.D. From *Medico-Legal Journal*, for September, 1887. 7 pp.

A CASE OF GASTROSTOMY FOR CANCER OF THE ŒSOPHAGUS. By J. COLLINS WARREN, M.D. From the *Medical Record*, November 5, 1887. 8 pp.

—Dr. Hughes's pamphlet is so interesting that we were not altogether surprised to find it printed as an original communication in a medical journal of this city three months after it had been published in the *Alienist and Neurologist*, and about a month after the reprint from this journal was on our table for notice. The author supports the physical, as opposed to the metaphysical view of the nature of insanity, and holds that it is a psycho-somatic disease, and contends that "wherever the *ante-mortem* and *post-mortem* search has been sufficiently thorough, somatic as well as physical aberrations have been found." We are not familiar enough with the literature of alienism to be sure that this statement is absolutely correct. But we would accept it with some reserve.

—Dr. Leonard's paper has been made the foundation of an Editorial in the REPORTER for December 31, and we simply call attention to it here as a very interesting and suggestive presentation of an important phase of medical practice: the duty of the physician to consider the needs of his patients with a due regard to their opinions and just desires.

—Prof. Reese answers in the negative the question: Can chemists decide whether arsenic found in the tissues of a dead body has been administered before or after death in cases in which arsenic has been injected into the body after death, presumably for the purpose of concealing a crime? He describes experiments conducted under his direction, in order to determine this matter, and refers to others, suggesting further experimentation with precautions calculated to prevent certain errors.

—Dr. Warren describes an interesting case, in which he made a permanent opening in the stomach of a man 56 years old, with a rapidly progressing cancer of the œsophagus. The patient lived for four months after the operation. One of the most interesting features of the treatment was the attempt to fit into the opening in the stomach and abdominal wall a pessary which would prevent leakage of the contents of the stomach; and the suggestion of an operation to make a valve-like fold of mucous membrane, to hang over the orifice, such as existed in the well-known case of Alexis St. Martin. Dr. Warren has succeeded in making a fistula in the stomach of a dog so protected, and is engaged in further experiments in this direction.

Correspondence.

Twins, One of Each Sex.

Ed. Med. and Surg. Reporter:

Sir:—The following question was propounded to me: "In cases of twins, one being a male, the other a female, is the female necessarily or frequently barren?" I answered in the negative. My questioner then wished to know whence originated the idea that in lower animals—citing the cow as an example—such was the case, and referred to Webster's definition of "free-martin." Can you, or any of your readers, throw light on the subject? I do not believe any such idea, and so answered. Yours, etc.,

T. J. Happel, M.D.

Trenton, Tenn., Dec. 29, 1887.

[We agree with our correspondent in regard to this belief.—Editor Reporter.]

The Conjugal Question.

Ed. Med. and Surg. Reporter:

Sir:—The numerous facts and frank opinions expressed in the Reporter by various members of the medical profession—in response to your request for a free discussion of this subject—are creditable to their respective authors. With a hope to see it more fully agitated, I offer the following remarks.

There is probably no topic within the whole domain of medical science which is at once so delicate, and so vital for the members of the medical profession to fully consider, as the subject of the conjugal relation. There is nothing so conducive to the individual happiness or suffering of mankind as connubial or concubinal sexual intercourse.

Sexual intercourse was originally designed for the purpose of propagating the human race. Hence it is an imperious necessity to human life. With normal, connubial usages, it is the chief preserver of virtue, health and morality. Practiced promiscuously and lustfully, with concubinal usages, it is a chief promoter of vice, disease and sin, and the gratification of a passion, for which man will brave any danger, however great, to health and even life.

All men have a repugnance to referring to these matters; but it is our duty, as right thinking, progressive members of the noblest of all professions, to use our best endeavors to suppress an evil far more pernicious in its influence and effects upon mankind than any other of which we have any knowledge, namely, promiscuous and lustful sexual intercourse—concubinage.

Again, this evil is very great, in view of the fact that it is the channel through which three of the most destructive diseases to mankind, viz., syphilis, scrofulosis and tuberculosis are conveyed. The time will come, I firmly believe, when the pathologist will establish the fact in science, which practical experience already confirms, that syphilis, scrofulosis and tuberculosis are akin, and originate in impure sexual intercourse. When this fact is established, and our knowledge of the danger of impure sexual intercourse reaches its proper limits, we shall have an argument against it which will strengthen the hands of those who wage warfare against what is destructive to the bodies as well as to the souls of our fellow-men.

Yours truly,

William B. Dewees, M.D.

Salina, Kansas, Dec. 29, 1887.

A Bad Burn.

Ed. Med. and Surg. Reporter:

Sir:—Mrs. N., age 67, on Nov. 15, 1887, accidentally put her right foot into a vessel of scalding water; when she removed her slipper and stocking, the integument came off of her foot and leg to about six inches above the ankle. I was not called until the 18th, when I found her suffering a great deal, and the wound discharging considerably. She had applied linseed oil and lime-water. On the 22d, I dressed the wound with a powder of subnitrate of bismuth and sulphate of morphia for twenty-four hours. The wound then looked better, and I renewed the use of linseed oil and lime-water. The wound progressed nicely until the morning of Dec. 20, when I found the foot and ankle red and œdematous. The woman's pulse was 110, her temperature 101°, with every evidence that I had a case of erysipelas to deal with. I now gave her:

Tr. ferri chlor.....f℥iss
Tr. digital.....f℥ss
M. Sig.—Cochl. parv. t. d. in half a tumblerful of water.

I also ordered a teaspoonful of sulphate of magnesia to be given every three hours until the bowels moved freely.

By the evening of the next day all the swelling and redness had disappeared, and the case is now recovering nicely.

Yours truly, G. G. Morris, M.D.

708 13th Street, N. W., Washington, D.C.

Jan. 9, 1887.

Ed. Med. and Surg. Reporter:

Sir:—I send you a recipe from a work entitled "Pharmacopœia Officinalis and Extemporanea; or, A Complete English Dispensatory," in two parts, theoretical and practical; printed in London, in 1741. There are many other recipes of similar character; and some still more disgusting. I copy exactly as given:

Vinum Millepedum,
Hog-lice Wine.

Take hog-lice, half a pound, put them alive into two pounds of white port wine, and after some days infusion strain and press out very hard; then put in saffron two drachms, salt of steel one drachm, and salt of amber two scruples, and after three or four days strain and filter for use. This is an admirable medicine against the jaundice, dropsy or any cachectic habit. It greatly deterges all the viscera, and throws off a great deal of superfluous humors by urine. It may be given twice a day, two ounces at a time.

I send an extract from a small work, entitled "Blair on the Grave." I copied it about forty-eight years ago. Never could obtain the book since, and never met with any person who ever saw it, though I have inquired of many. You might find use for it in giving some eminent deceased "Son of Esculapius" a proper obituary notice:

"Here the great masters of the healing art,
These mighty mock defrauders of the tomb,
Spite of their juleps and catholicons,
Resign to fate proud Esculapius' son.
Where are thy boasted implements of art,
And all thy well-crammed magazines of health?
Nor hill, nor vale, as far as ship could go,
Nor margin of the gravel-bottomed brook,
Escaped thy rifling hand; from stubborn shrubs
Thou wrung'st their shy, retiring virtues out,
And vexed them in the fire; nor fly, nor insect,
Nor writhy snake, escaped thy deep research.
But why this apparatus, why thy cost?
Tell us, thou doughty keeper from the grave,
Where are thy recipies and cordials now,
With the long list of vouchers for thy cures?
Alas! thou speakest not. The bold impostor
Looks not more silly when the cheat's found out."

Yours truly,

John C. Richards.

Philipsburg, Pa., Jan. 7, 1888.

—Women doctors and missionary doctors in the northwest of India and of Oude are coming prominently into notice. Nearly 72,000 cases were treated at eleven missionary dispensaries, and 11,000 women sought relief at Mrs. Wilson's dispensary, at Agra; 10,850 women and children were treated at the Thompson dispensary, at Agra; and the doctor in charge successfully performed some very important surgical operations.

Notes and Comments.

Childbirth in a Railway Car.

Dr. William Osler narrates the following remarkable story in the *Canada Medical and Surgical Journal*, January, 1888:

"Dr. Parvin's paper on injuries to the fœtus (read before the Philadelphia County Medical Society, Oct. 26, 1887) reminds me of an interesting experience which I had in the Northwest in 1886, which is worth placing on record. Mr. Fred. Brydges had kindly met our party at the Portage to take us over the Manitoba and Northwestern Road, and he mentioned that, two days before, a woman, while in the water-closet on the train, had given birth to a child, which had dropped to the track and had been found alive some time after. I was so incredulous that he ordered the conductor to stop the train at the station to which the woman had been taken, that I might see her and corroborate the story. I found mother and child in the care of the station-master's wife, and obtained the following history: She was aged about 28, well developed, of medium size, and had had two previous labors, which were not difficult. She had expected her confinement in a week or ten days, and had got on the train to go to see her husband, who was working "down the track." Having a slight diarrhœa, she went to the water-closet, and while on the seat labor-pains came on, and the child dropped from her. Hearing a noise and groaning, the conductor forced open the door and found the woman on the floor in an exhausted condition, with just strength enough to tell him that the baby was somewhere on the track, and to ask him to stop the train, which was running at the rate of about twenty miles an hour. The baby was found alive on the side of the track a mile or more away, and with the mother was left at the station where I saw her. She lost a good deal of blood, and the placenta was not delivered for some hours. I saw no reason to doubt the truthfulness of the woman's story, and the baby presented its own evidences in the form of a large bruise on the side of the head, another on the shoulder, and a third on the right knee. It had probably fallen between the ties on the sand, and clear of the rail, which I found, on examination of the position of the hole in the closet, was quite possible."

Syphilis Communicated By Tattooing.

In the *British Medical Journal*, December 10, 1887, A. Porter, surgeon to 1st

Battalion Middlesex Regiment, reports that Lance-Corporal B. was admitted into the station hospital, Dover, in 1886, suffering from two ulcers on the left forearm.

A week prior to admission his forearm, at the site of the ulcers, was tattooed by a comrade who had been discharged from hospital about a fortnight previously, where he had been a patient, suffering from a well marked attack of syphilis. The ulcers, two in number, were somewhat crescentic in shape, had each a diameter about the size of a florin, and were slightly blue in color from the staining of the Indian ink. They did not show any tendency to heal, and looked like chancres. The glands in the axilla became indurated and enlarged. Eight weeks after his admission a copious rash of a specific character appeared over his body.

On questioning the patient closely, the doctor found that during the process of being tattooed, the operator spat on the patient's arm and then rubbed it, in order to remove the blood which flowed at each puncture of the needle. As the operator had recently suffered from an attack of syphilis, the presumption is that the virus was conveyed to Lance-Corporal B.'s arm through the saliva of the tattooer. There was no evidence to show that Lance-Corporal B. ever had a primary sore prior to this. The usual treatment for syphilis was adopted; the eruption soon disappeared, but the ulcers were long in healing.

The Influence of Heredity upon Deformities and Defects.

The *British Medical Journal* says that some interesting observations bearing upon intermarriage and the recurrence or exaggeration of hereditary defects were brought before the Clinical Society recently, when Mr. Clement Lucas read a paper on "The Congenital Absence of an Upper Lateral Incisor Tooth as a Forerunner of Hare-lip and Cleft-palate." It is now very generally recognized that a defect from arrest of development in any part is liable to be repeated again and again, in succeeding generations, in spite of the introduction of new blood at each marriage. In illustration of this Mr. Lucas referred to a former observation of his, that among eighty descendants of a woman who had supernumerary digits, thirty per cent. presented a similar deformity. He also alluded to the case of a woman who married after having been successfully operated upon for cleft-palate and hare-lip; two of her six children presented a deformity similar to that of the mother. He now wishes us to go a step further, and detect a deformity, as it were, in an initial stage. He brought forward three cases to prove that a tendency to the congenital absence of a lateral incisor tooth might be transmitted as such, or might become the parent of hare-lip or cleft-palate. The absence of this tooth, it was explained, indicated an arrest of development along a particular line, which might in a future generation extend either to the lip or palate. Dr. Goodhart showed at the same meeting five children of one family, all of whom had nystagmus and staggering gait. The parents were first cousins, and there had been a former marriage of cousins on the mother's side, whilst on the father's side several relatives were deaf.

Deodorants for Iodoform.

Oil of turpentine has been recommended as a very efficient deodorant for the hands or for utensils, after they have come in contact with iodoform. They are first thoroughly rubbed with oil of turpentine, and, after about half a minute, washed with soap or soap spirit. It is also asserted that a watery solution of tannic acid, which leaves no odor of its own, destroys that of iodoform immediately, and can be washed off at once.

Pruritus Ani.

Dr. W. Mitchell Banks writes to the *Liverpool Med. Chir. Journal:* "I have been rather struck with the frequency of pruritus among the better classes of society as compared with the hospital classes. Out of 4000 cases occurring at St. Mark's Hospital in London, under the care of Mr. Allingham, only 180 were cases of pruritus. And we may be sure that a very large proportion of all the cases in London would be sure to find their way to a special hospital. I see plenty of cases of piles and fistula at the Liverpool Royal Infirmary, but I cannot get hold of a genuine good case of pruritus, whereas in private practice they are by no means uncommon. Cleanliness then can have nothing much to do with it in point of causation. Again, while probably showing a predilection for those who eat and drink too much, it assails people of very different appearance and habits. I cannot help thinking that it is in many essentially a gouty condition, and I found a course of Homburg do one patient great good—indeed it practically cured her, after everything else had failed. There is a method of treatment which I do not think is spoken of in books, but which I have tried

in two or three cases with great success. This consists in anæsthetizing the patient, and then with the big bulb of a thermo-cautery, heated to a white heat, lightly running over the whole affected surface, so as to produce a superficial burn. This seems a rather severe remedy, but then the disease is sometimes a very dreadful one, and makes the lives of its victims almost intolerable. Now, the look of the cautery is much worse than the reality, and a bit of lint kept moist with a solution of carbonate of soda soon takes the smarting away. I do not know if others have tried this plan, but it is an excellent one, and may be resorted to with tolerable confidence in aggravated cases. Deep cauterization is not required, merely a superficial frizzling."

Albuminuria from Irritating the Pneumogastric Nerve.

At a meeting of the Biological Society of Paris, MM. Arthraud and Butte demonstrated that lesions of the peripheral termination of the vagus nerve, produced by injections of lycopodium powder suspended in water, occasioned a nephritis with albuminuria, which developed slowly.

In a new note by M. Raymond, these experimenters announce that analogous results are obtained by the injection into the pneumogastric of an irritant liquid, such as very dilute croton oil. In this latter case the progress of the disease is very rapid, and hemorrhages occur in the skin, muscles and digestive apparatus. The nephritis which arises is diffuse.—*Bulletin Médical*, Dec. 7, 1887.

For Toothache.

Alcoholic ext. of opium,
Powdered camphor,
Balsam of Peru....of each 7½ grains
Mastic.....15 grains
Chloroform .....2½ drachms.

M.—Moisten a pledget of absorbent cotton with the liquid, and insert it in the cavity of the painful tooth.—*Union Médical.*

A Vesical Calculus with an Unusual Nucleus.

Dr. Lewis W. Rose, in a communication to the *Medical Record*, Dec. 17, 1887, reports the case of a man 58 years old, who came under his care suffering from urethral stricture and chronic cystitis. The stricture was cured by the introduction of sounds, and the urethra dilated so that a No. 19 English was readily passed. A stone having been detected on November 9, a drachm of four per cent. solution of cocaine was injected deep into the urethra, and a Bigelow lithotrite passed into the bladder. A mass about one inch in diameter was seized and crushed. Much difficulty was experienced in withdrawing the instrument. After half an hour of careful and patient manipulation, a leather shoestring, ten inches in length, was extracted, with but little discomfort to the patient. The string was massed between the blades of the lithotrite, and incrusted with phosphatic deposit. The patient denies any knowledge of how the string came into the bladder. He always enjoyed having sounds passed, and several times experienced sexual excitement during their introduction. At present he is progressing favorably.

A somewhat similar case was recently reported to the Academy of Surgery of Philadelphia, by Prof. S. W. Gross; but in his case the nucleus of the calculus was a fragment of a ligature, about an inch in length, which had remained in the bladder following an operation by a German surgeon.

Pyridin as a Heart Stimulant.

In the *Deutsche Medizinal-Zeitung*, November 24, 1887, it is stated that de Renzi (*Riv. clin. e terap.*, No. 3, 1887) from practical observation of seven patients in his clinic, has come to the following results:

1. Pyridin taken internally, beginning in doses of 6–10 drops in water daily, is well borne by patients, and this dose can by gradually increased up to 25 drops a day and over. 2. It markedly increases the power of the cardiac systole and diminishes the sensation of oppression and anxiety. One can also judge objectively of the more energetic systole of the heart through the stronger impulse of the latter. 3. The number of systoles diminishes after the use of pyridin correspondingly with the number of respirations. 4. By the use of pyridin the arterial pressure is raised, as was proved by the sphygmomanometer. Tracings also show that the pulse is rendered more regular. 6. It disposes of attacks of angina more quickly and more completely than any other remedy. It shows itself active in asystole, and that more quickly than digitalis, whose cumulative action, moreover, is avoided.

Formula for Creasote in Phthisis.

The following is Huchard's formula:

℞ Creasoti,
Iodoformi,
Pulv. benzoini,
Balsam. Peruv.....āā gr. ¾.

M. S.—For one pill. One or two to be taken at each meal.—*Revue de Clin. et de Thérapeutique.*

Fatty Degeneration of the Heart from Intra-Abdominal Pressure.

At the meeting of the Pathological Society of London, on November 8, 1887, Dr. Bedford Fenwick (*Lancet*, December 10, 1887) read a paper on cardiac degeneration due to abdominal disease. He related the case of a woman, forty-five years old, who had been married twenty-two years. She presented a uniformly distended abdomen; the heart sounds were dull. She was operated upon, and an ovarian tumor, weighing twenty-two pounds after all the fluid had been discharged, was removed. The wound of operation healed by first intention, but on the eleventh day the patient became very ill and peritonitis set in, followed by death on the twelfth day. The heart muscle was pale, yellow, soft, and friable; the wall of the right ventricle was very thin, but the wall of the left ventricle was of natural thickness. Microscopic sections showed fatty infiltration and degeneration of the heart muscle. He believed that such a condition could cause rapid collapse and death, and that it was, in fact, the pathology of twenty-two fatal cases in which the general condition was well marked. He suggested that the effects of direct pressure were the probable causes of the degenerative change, which, he said, was proportional to the duration and size of the abdominal mass; such a physical explanation being obvious, there was no need to invoke more obscure agencies. The majority of cases occurred under the age of fifty, and yet fatty degeneration of the ordinary kind was most frequent in males above that age.

Naphthol as an Antiseptic.

M. Bouchard, in *Comptes Rend.*, gives his experience with this substance and claims that Beta naphtol is absolutely safe in any form it is likely to be administered. Experiments on animals prove conclusively that it would require nearly one half pound of it taken internally to produce fatal results on a healthy person weighing one hundred and fifty pounds. When injected into the veins of animals as a one per cent. solution, the amount to produce fatality was equal to 400 grains for an adult of one hundred and fifty pounds. Ten grains in a quart of water will prevent the growth of any organisms. It has five times the antiseptic power of carbolic acid, four times that of creosote, three times that of iodoform, five times that of iodol, four times that of naphtaline, but has only $\frac{1}{20}$ the destructive energy of biniodide of mercury.—*Pharmaceutical Record.*

NEWS.

—The hundredth birthday of the celebrated anatomist and physiologist, Johann Evangeliste Purkinje, has just been celebrated at Breslau.

—A man is said to have died in Cincinnati recently for the want of medicine, which could not be compounded because the druggist was unable to decipher the prescription in the case.

—In Paris, during the week ending December 10, 1887, there were 1209 births. Of these 622 were males, and 587 were females. Of the whole number, 335—more than one-fourth—were illegitimate.

—The late Dr. James R. Nichols, of Haverhill, Mass., was a well-known and much-esteemed citizen, distinguished for his public spirit, his scientific achievements, and his capacity as a business man. He was an editor, a chemist, and a railroad manager, and had filled most all the positions creditably.

—Where ice cannot be procured, water may be cooled by wrapping the pitcher containing it in a towel of loose texture which has been previously impregnated with ammonium nitrate (*and dried*), and moistening this with water. The same towel may be used repeatedly, being dried thoroughly beforehand each time.—*Phar. Era.*

—A simple method of preserving fresh fruit is to place it in a wide-mouth, glass-stoppered bottle with a little chloroform. The stopper of the bottle should be greased with a little petrolatum to make it air-tight. A drachm of chloroform suffices for a quart bottle. The chloroform soon evaporates on exposure to the air, or is dissipated in cooking.—*Phar. Era.*

—In concluding a paper in *Science*, January 6, 1888, upon the question whether forests influence rainfall or not, Henry Gannett says: "It seems idle to discuss further the influence of forests upon rainfall from the economic point of view, as it is evidently too slight to be of the least practical importance. Man has not yet invented a method of controlling rainfall."

—The New York Academy of Medicine has just received a valuable addition to its library of 30,000 volumes in the shape of 6000 standard works. They are the bequest of Dr. Middleton Goldsmith, of Rutland, Vt., recently deceased, and came through Dr. John C. Peters, of New York, who for nearly half a century was a warm personal friend of Dr. Goldsmith.

—The President has sent to the Senate the nomination of Henry Leffmann, of Pennsylvania, to be Coiner of the Mint at Philadelphia. Dr. Henry Leffmann was born in this city, forty years ago, and is a graduate of the Central High School and of the Jefferson College. He is Professor of Chemistry in the Wagner Free Institute of Science, and an honorary member of the State Board of Agriculture.

—Mr. Ford H. Carruth, the "funny man" of the Chicago *Tribune*, occupies more than half a column of the issue of that newspaper for January 6, with a stricture upon physicians, and especially upon young physicians. The comments he makes are not very amusing, and they are very unjust. He must have been unfortunate in his acquaintance with doctors; and if the medical men in Dakota find out what he says about them, it will try their benevolence pretty severely if he ever falls sick in their part of the country.

—The whiskey detective has, of late, been very busy in Toronto, and a large number of druggists have been brought before the police magistrate. In all instances in which convictions were obtained, a fine of $20 and costs was inflicted, and some parties, against whom two charges were made, were subjected to a second fine. We have always held that it would be better for druggists to abandon, completely, the sale of liquor, and we believe that in the long run it would pay. The methods pursued by the informer here were of a very questionable character and have called forth much indignation from druggists.—*Canadian Phar. Journal.*

—Several months ago a doctor went to Chicago and commenced the practice of medicine. He advertised extensively the cure of a special class of diseases, when the State Board of Health interfered and revoked the doctor's certificate. The doctor then commenced an action against the State Board in the Circuit Court. Recently, Judge Waterman decided the case, and declared the act of the State Board of Health unconstitutional. He said: "The right of a party charged with a punishable offence to notice of hearing is elementary, and one of the first rules necessary to the administration of justice. The defendant had a perfect constitutional right to advertise in the newspapers, and he cannot be deprived of it by any rule or regulation of the State Board of Health. This association, if its action was to be held legal in this case, could summarily try and punish for an alleged offence a brother practitioner without any notice whatever."

HUMOR.

A LITTLE BOY was taken sick for the first time, and the doctor, with much ceremony made him swallow a powder. "Papa, said the boy, a minute later, "ain't it time I was taking the *shot*, now?"—*Puck*

AN ambiguous compliment: "If you use my mixture once," said a patent-medicine man, "I'm sure you will never use any other." "No," was the reply, "I don't suppose I ever would."—*Judge.*

MACON (GA.) *Telegraph* says: They call it "Mind-cure" in Boston and "Voudooism" on the Southern plantations; but about the only differences is in the name and in the fact that the Voudoo charges less.

THE LONDON *Globe* says: It is comforting to find that the boiling point of "allylenedichlordibromide" is 190°, while that of "methylchlordibrompropylcarbinylchloride" is something between 140° and 145°.

A MATCH VENDER entered a butcher's shop, when the following brief dialogue was heard: "Vender—"Hello, chops! How's your liver to-day?" Chops—"Three cents a pound. How's your lights?"—*Lowell Citizen.*

A TEACHER said to a member of the State Board of Health who was investigating the condition of her room, "No, I haven't any ventilators: I don't see any use for them." "But how do you keep the air pure?" "Oh, I've got a thermometer."

REQUIRES PERSEVERANCE.—"Young man," said a cross old lady on a street car, "terbacker smoking makes me sick."

"It used to make me sick, too, ma'am," replied the young man, lighting a fresh cigar; "but, Lord, you'll get used to it after a while."—*New York Sun.*

HE COULDN'T AFFORD IT.—A mother was urging her son to purchase an overcoat and he was insisting that he could not afford one.

"Very well, then," said she, "you will get pneumonia, see if you don't."

"No," said he, "I won't get that either; I can't afford anything new."—*New York Sun.*

A MISER, troubled with heart-disease, finally decided to call a physician. After the preliminary examination the patient asked: "Doctor, how much is it going to cost?" "Not a sou." "Thanks; but you're too kind. I ought not to—" "O don't trouble yourself! Your heirs will see that I am paid."

A DOCTOR near Louisville, Ky., fell off his chair while taking a nap on the porch of his dwelling recently, and a pistol in his coat-

pocket was discharged, killing him almost instantly. The occurrence has awakened a strong feeling among the people of that vicinity against the practice of sleeping in chairs.

IT IS A WISE FATHER that knows his own child.—The *Pittsburgh Med. Review* says editorially: The March number of the *Review* contained a translation from the *Centralblatt für Gynecologie* of a case of tuberculosis of the peritoneum cured by laparotomy, which was performed by Dr. Poten, of Hamburg. In April the *Medical Record* printed the report, giving proper credit; and now the same article, retranslated into German, adorns the September issue of the *Centralblatt*, as a report by Dr. Poten, of Pittsburgh. The short sojourn of a few months in this country had so Americanized this assisted immigrant that he returned as a stranger to the place of his nativity.

OBITUARY.

DR. CYRUS N. BLOUNT.

Dr. Cyrus N. Blount died after a short illness at his home in Kokomo, Indiana, on Wednesday, December 28. Dr. Blount was born August 26, 1832. He was graduated in 1858, from Butler University, at Indianapolis, in which city he began the study of medicine. A few years afterward he took the degree of M.D. at the Jefferson Medical College, Philadelphia. He practiced his profession for eleven years at Tipton, Indiana, and for fifteen years at Hagerstown, Indiana. He removed to Kokomo, Indiana, in August, 1887, to accept a partnership with Dr. Armstrong, a leading physician of that place. As a practitioner of medicine Dr. Blount was highly successful, being a man of much more than ordinary ability and always genial and courteous toward his brother physicians, and ready to extend a helping hand to the younger men in the profession. He was an active member of the Indiana Medical Society, of the Eastern Indiana District Medical Society, and of the Wayne and Henry County Medical Societies. As an essayist Doctor Blount had few superiors, and he was a ready and apt speaker upon any subject. His character was thoroughly Christian, and no sacrifice was too great for him to make for the church he loved. He was a stanch advocate of the temperance cause.

Doctor Blount was twice married, his first wife who lived only a short time after her marriage, being a sister of Judge N. B. Taylor, of Indianapolis. Some years after her death, he married Miss Fannie A. Dyer, by whom he had three children. His wife and two sons survive him. J. N. S.

JOHN P. SEILER, M.D.

Dr. John P. Seiler died suddenly in Harrisburg, on January 5, 1888, at the age of 42. He made his regular calls on patients on Tuesday, but on Wednesday (January 11) was confined to the house by an attack of rheumatism, a disease to which he was subject. On Thursday morning he was found in a comatose state, and an hour later died. Dr. Seiler was a leading physician and surgeon, and his practice was extensive.

WESLEY M. CARPENTER, M.D.

Dr. Wesley M. Carpenter, Professor of Clinical Medicine in the University of the city of New York, was found dead in bed in his home in New York on Saturday, January 7. He had been a sufferer from heart disease for some time.

THOMAS WARDLE, M.D., D.D.S.

Dr. Thomas Wardle died in Philadelphia, on December 5, 1887, in the 69th year of his age.

Official List of Changes in the Stations and Duties of Officers serving in the Medical Department, U. S. Army, from Jan. 8, 1888, to Jan. 14, 1888:

Capt. Louis S. Tesson, Assistant Surgeon, relieved from duty at headquarters, Div. of the Missouri, and as Examiner of Recruits at Chicago, Ill., and ordered for duty as Post Surgeon at Watervliet Arsenal, N. Y., relieving Capt. Henry G. Burton, Assistant Surgeon, S. O. 5, A. G. O., Jan. 7, 1888.

Capt. Richard Barnett, Assistant Surgeon, ordered from further duty in Div. of the Atlantic, to duty at Fort Riley, Kan.; to take effect at the expiration of his present sick leave. S. O. 5, A. G. O., Jan. 7, 1888.

Official List of Changes of Stations and Duties of Medical Officers of the U. S. Marine Hospital Service, for the week ended Jan. 14, 1888:

George Purnance, Surgeon, to proceed to Detroit, Mich., as inspector of unserviceable property. Jan. 11, 1888.

H. W. Austin, Surgeon, when relieved to proceed to Chicago, Ill., and assume charge of the Service. Jan. 12, 1888.

J. M. Gassaway, Surgeon, leave of absence extended fifteen days. Jan. 10, 1888.

C. B. Goldsborough, Surgeon, when relieved to proceed to New Orleans, La., and to assume charge of the Service. Jan. 12, 1888.

Fairfax Irwen, Surgeon, to proceed to Boston, Mass., and assume charge of the Service. Jan. 12, 1888.

H. R. Carter, Passed Assistant Surgeon, when relieved to proceed to Ship Island Quarantine, Miss., and assume temporary charge of the Service. Jan. 12, 1888.

P. M. Carrington, Assistant Surgeon, granted leave of absence for thirty days. Jan. 10, 1888.

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Communications.

ATTEMPTED NEPHROLITHOTOMY; WOUND OF THE DIAPHRAGM; RECOVERY.

BY JOHN B. ROBERTS, M.D.,

Professor of Anatomy and Surgery in the Philadelphia Polyclinic.

I report the following case of attempted nephrolithotomy, which occurred, in the spring of 1886, in the person of a private patient at the Polyclinic Hospital, as a contribution to the literature of the subject; and because I believe it to have been the first case of the kind occurring in Philadelphia. Since the operation here reported, Dr. S. W. Gross has performed at the Jefferson College Hospital nephrolithotomy, and successfully extracted the calculus from the pelvis of the kidney.

S. B., aged 39, had for the last two years suffered with pain in the region of the left kidney, which had troubled him almost incessantly. He came to Philadelphia with the hope that some treatment might be instituted which would relieve him from his suffering, which had failed to yield to the ordinary methods of treatment. After careful examination of the case, and consultation with the other surgeons of the Polyclinic Hospital, I determined that there was sufficient reason to believe the pain due to renal calculus, and, therefore, that an exploratory operation in the lumbar region was justified. Accordingly, on May 20, 1886, I made an incision in the left loin, and at once came upon the left kidney. In order to get more room, it was determined to cut a few muscular fibres which extended across the upper angle of the wound a little distance below the surface. Accordingly, they were divided and instantly the sucking of a large quantity of air into the pleural cavity showed that these fibres were a portion of the attachment of the diaphragm to the posterior wall of the abdominal cavity. The opening, which was a very small one, was of course close to the vertebræ. The tissue was not recognized as a part of the diaphragm before being cut, because it was posterior to the bulging portion of the diaphragm which was seen at the bottom of the wound. The opening so made was closed by silk sutures with no other difficulty than that it was difficult to get the sutures to draw the edges of the orifice close together on account of the muscular fibres being tensely attached to the bone. It would have been very easy to close a similar puncture situated further out in the flaccid portion of the muscle.

The surface of the kidney was felt with the tip of my finger without discovering any sign of stone. I then thrust a long needle in various directions through the kidney structure towards the calices without coming in contact with any hard substance. The operation was an exceedingly easy one in all its details, with the exception above mentioned of the trouble experienced in sewing up the small opening in the diaphragm. A small aseptic sponge, previously dusted with iodoform, and with a short string attached to it, was thrust into the wound against the injured diaphragm. The external incision was then closed with five wire sutures, the string attached to the sponge left hanging from the wound, and the parts dressed with carbolized oil and a bandage. The following day the wound was dressed with sublimate cotton, and on the third day the sponge was removed, at which time a large portion of the external wound had united by first intention. Subsequently, there was some suppuration in the

wound, and it was syringed with a solution of bichloride of mercury, 1 to 1000. The temperature which had been comparatively high for a day or two previous to the beginning of the syringing, soon fell, although it did not come down to the normal for a number of days. For a few hours after the operation, the urine was somewhat bloodstained, but soon became of normal color. On the tenth day after the operation, catheterization drew off a pint of dark-colored urine, which he was unable to pass naturally. The wound was not being dressed at this time with carbolic acid, nor had it been since the first day, as the mercurial dressing had been employed in connection with the iodoform powder. As time went on the patient became anæmic: the portion of the wound which had not healed became sluggish in appearance; the man's general condition deteriorated and his appetite became poor. About a month after operation, he complained of considerable pain deep in the wound, which made it impossible for him to lie comfortably in bed. This was particularly noticeable because the pain from which he suffered previous to the time of the operation had been greatly alleviated by that procedure, although no stone had been found in the kidney. The mere fact of operation had made him much more comfortable, although it was difficult for me to understand why so much relief was given without a more patent cause having been removed. Subsequent to the advent of the deep pain just mentioned, there was suddenly a discharge from the wound of a large quantity of watery and purulent fluid which soaked entirely through the dressing and clothing. This material was examined to see if it contained urine, but the result was negative. It was, I believe, considered by Dr. W. B. Hopkins, who had charge of the case at that time for me, to be due to the rupture of a kidney cyst. Although this fluid apparently contained no urine at first, the discharge which continued soon assumed a urinous odor. From this time the patient gradually improved, and, after a stay of about two months in the hospital, returned home. There was about an eighth of an inch of uncicatrized wound from which there was a slight discharge of pus. I heard from him a number of times after his return to the country, but the reports were never very favorable. He was well enough to be up and about and able to go out, but did not become strong and vigorous, nor did the wound entirely heal. At times there was a good deal of pain in and around the wound. After a few months' time, he gradually failed and died with no other diagnosis of the cause of the pain being made; and, as far as I know, no autopsy was made.

The case is reported as I have said above, simply as a contribution to renal surgery, and to show with what ease the diaphragm may be punctured by an incision which apparently is far from it, because of the way in which the posterior border of the diaphragm takes its origin along the spinal column. The case is also important, I think, as showing how innocuous such a wound of the diaphragm is if promptly sutured and treated in an antiseptic manner.

For the notes of the case, I am indebted to the House Surgeon at the Polyclinic Hospital, Dr. W. H. Hale.

1627 Walnut St., Philadelphia.

THE TREATMENT OF DIPHTHERIA.

BY JOHN PIRNAT, M.D.,
EVANSVILLE, IND.

I would like to give to the readers of the REPORTER my treatment of diphtheria. My formula, which was published a year ago in my pamphlet on diphtheria, is—

℞ Potassii chlorati.....3v
Calcii sulphurati.....3j
Magnesiæ phosphatis.....3j
Pulv. sacchari aromat.....q.s. ad ʒij

Misce, et fiatpulvis subtilissime. S.—Dose for an adult, sixteen grains every two or three hours; for a child of six years, eight grains.

I have prepared this formula myself for the last twelve years by rubbing the different ingredients into an impalpable powder, adding the aromatic sugar last, thus making it of quick absorption, and not unpleasant to the taste. This is an important point with children and infants. If the prescription is sent to a drug store, the ingredients will be put together into the mortar, rubbed for a while, and divided into powders, which will be not only unwholesome, but at the same time disagreeable to take.

The second preparation which I use is the so-called "anti-diphtheriticum," composed of C. P. naphthalin, tincture of pine gum, and compound elixir of orange peel. This is a private formula of my friend Dr. L. Dohme, and is given to the profession at at my own instigation. It is superior to my preparation, and almost specific in this disease. Although it is a proprietary medicine, I find it no more unprofessional to prescribe than Dr. E. Williams's improved brown citrine ointment, which is a valuable remedy for chronic ophthalmia and phlyctenular con-

junctivitis, and sold only by Mr. Fennel, of Cincinnati, as "Prof. E. Williams's private formula," at four dollars per pound. I hope the esteemed Professor will give this excellent formula and its therapeutic uses, to the profession, as a remembrance of his name for time to come.

Although I have implicit confidence in these two preparations as curatives in diphtheria, still in all cases of severe character, or with complications, I resort from the very start to other adjuncts, as a safeguard. For instance, if malaria is suspected, quiniæ sulphas, tinct. ferri chloridi, and glycerine, in proportionate doses, are given between the other remedies. In extensive formation of plastic exudation, or if the membrane is dark grayish looking, and the patient old enough, I order the following preparation as a gargle:

℞ Acid. carbol ..... f℥ss
Ext. eucalypti glob. fl .. .. f℥x
Ext. pini Canad..... f℥ij
Glycerinæ..... f℥ij
Aquæ..... q.s. ad f℥viij
M. S.—Gargle well every two hours, for ten minutes each time, before taking the medicine.

For children:

℞ Tripsin..... ℥ss
Sodæ bicarbon..... ℥ss
Hydrarg. chloridi corros..... gr. ¼
Glycerinæ..... f℥j
Aquæ rosæ..... f℥vij
M. ft. sol. S.—Spray every time before medicine is given.

Or,

℞ Acidi lactici..... f℥ij
Hydrarg. chloridi corros..... gr. ss
Glycerinæ..... f℥ij
Aquæ..... q.s ad f℥iv
M. ft. sol. S.—Spray each time before giving the medicine, applying a cloth dipped in cold vinegar (not too wet) to the neck.

Of late years my rule in treating cases of diphtheria is to give the diphtheritic powders and the "anti-diphtheriticum" every hour and a half in alternation, day and night, until the diphtheritic membrane is entirely gone; then every two or three hours, for some days, until the patient is quite well; and then, if it is necessary, I prescribe either elix. phosph. iron, quinia and strychnia, or liq. potas. arsenitis, three times a day after meals. In cases of scrofulous or syphilitic taint, I order syr. ferri iodidi, or liq. potas. arseniti, to be taken after meals, and a cod-liver oil emulsion before meals.

In this city of about 40,000 inhabitants, we have had plenty of diphtheria within the last three years, and my success in treating it has been such that I have recorded only four deaths from this disease in the last twelve years; and in these cases the disease was complicated with membranous croup. It may be that I was lucky enough to meet only with benign cases. In conclusion, let me state that either the first or the second preparation will act as a preventive; and that, if it is given three or four times a day to children, where a malignant case exists, one need not be afraid of any trouble—at least this has been my experience thus far.

THE NATURE AND CURE OF SYPHILIS.

BY P. P. QUACKENBOSS, CHEMIST,
PHILADELPHIA, PA.

In the initial lesion of syphilis we find the skin or epidermis presenting an appearance very similar to that of a burn: we find the cellular structure disintegrated, and the virus penetrating into the lymphatic circulation rapidly. If, however, the virus is destroyed before this stage is reached, no evil effects are perceptible; but let it go on for a few hours, putrefactive matter accumulates, is absorbed, and carried into the circulation throughout the whole body by natural processes, which are well understood, creating those septicæmic conditions we are familiar with.

On looking for something to act as an example to illustrate germ-growth, nothing presents itself better than the Torula cerivisiæ, or yeast-plant, in its action upon "wort" in making beer. After the different constituents are mechanically put together, in proper proportions, the yeast is added, the conditions of heat and moisture secured and graded, and the first stage of growth is inaugurated. This demands one of the original elements for its existence, breaks up the chemical combination present, and produces a different one. These germs pass in turn through the different stages of access, accentuation, attenuation, and putrefaction; and if the same yeast is used through successive stages, it totally loses vitality, a fact well known to brewers. This is the basis for Pasteur's culture of bacterial growth, and this will help us to understand the different stages of the disease under discussion.

To make the virus of syphilis visible, we apply a solution of bichloride of mercury to the surface of the ulcer, in order to coagulate the albumin. Then wash it with a saturated solution of hyposulphite of soda to blacken it, in order to distinguish it from the cuticle. Tearing this off with a small for-

ceps and placing it upon a microscopic slide, we find underneath it a thin viscid fluid containing the cause of the trouble, as well as the excrementitial or putrefactive matter.

If we attempt to exterminate this growth by the old practice of burning, we find it too deep-seated to be reached with the limited means at our command, in nitric acid or its various compounds, and we only succeed in destroying a portion of it, and that the least active. If, however, we use one of the salts of potash, we can dissolve a part of the tissue surrounding these growths, and, following it with a solution of sodium salts, we can restore the tissue to nearly its normal condition; and if, during this change, the micro-organisms could be exposed to a dry air heated to 160° or over, they would be killed at once. So I am led to believe that, if these conditions can be arranged, the disease can be controlled.

In the past ages a system has been pursued (by physicians that depended upon that eminent empiric Paracelsus for their ideas) which maintained the use of mercury in combination with certain salts as a germicide. In view of the well known septicæmic action of any of these compounds, it is like a policeman shooting pistol balls into a crowd of ten thousand innocent men in order to hit one thief. Other practitioners have depended upon iodide of potassium—a combination of slow dissolution—together with certain alterative medicines, which certainly have an effect upon animal tissue under normal conditions, but under diseased ones may not act properly. Still, if we follow them chemically, we observe that the combination breaks up, and the iodine, being freed from the carbonate of potassa, seizes upon the proper chemical constituent that may be in juxtaposition to it, just as it does in the laboratory.

Iodine combines by natural affinity with an alkali, and of course seizes the most soluble one in the skin or in the mucous membrane, thus in its turn destroying the combination then existing, and, let us say, depositing a film of iodide of potash, in place of the carbon and potassium that already existed, which has to be eliminated in the regular method and time. What proof have we that, therefore, it destroys putrefactive matter in preference to live tissue?

We know that carbon gives stability to potassium and sodium, whether combined in the skin or not, governed solely by the amount contained in each. If, therefore, we find the cellular structure of skin broken down by the abstraction of some element by the germ, and discover that by treatment with a mixture of these salts, together with a germicide such as sulphur, the germ is killed, while the cellular structure is either restored, or, if taken in time, is prevented from destructive action, we are led to believe that those elements are demanded. Therefore, I would suggest the employment of aperient waters containing the elements of carbon, sulphur, potassium, and sodium, etc.; and, as the Turkish bath offers the most feasible method of exciting the skin to an abnormal excretory action, and at the same time exposing the germ to a heat that will kill it, say 170°, therefore add a Turkish, not Russian, bath at least three times a week, at the discretion of the physician. In experimenting, I have found that a hot application of a saturated solution of sodium hyposulphite will absolutely kill the virus in its early stages, and prevent inoculation, if applied within an hour after infection. The effect is enhanced by a previous use of carbonate of potassium in solution. In view of these facts, we have every chemical reason for believing that, in due time, the whole germ-growth can be exhausted. But patience and perseverance are both necessary factors in this method.

IMPERFECT PREPARATION FOR THE PRACTICE OF MEDICINE.

BY ENOS T. BLACKWELL, M.D.,
CEDARVILLE, N. J.

Much has been written in this country upon the rapid manner in which very young persons of limited education and moderate capacities are transformed into doctors, to whom are entrusted matters of life and death, affecting the people among whom they locate. When we reflect upon the acquisitions of those who teach, medical and literary, and realize that they must know how ill prepared are many of the newly-made professionals to sustain themselves respectably, either as regards the work done by them, or as social factors in their several localities, one can but wonder and deplore. It would seem that the blush of shame must often mantle a professor's cheek, as he sees the practical results of imperfect teaching in the creation of so-called "graduates," who have "small Latin and less Greek," and no competent knowledge of their mother tongue. The medicaments and prescriptions of some of these neophytes are such as to make a qualified pharmacist wonder and lament. The following case came under my own notice:

A young man, who had attained a working faculty in a pursuit where some knowledge of letters would be acquired by the dullest, in an evil hour, as it seems to me, bethought him to prepare for the practice of medicine. Procuring the catalogue of a prominent New York medical college, and such notions of the art of healing as he could gather without a preceptor, he entered its walls in the capacity of a student. Disposing of his time as circumstances dictated, he entered for a second course, falsely registering as having studied under a preceptor; and in due time was dismissed with a suave bow, and "*vale doctor.*" Settling down to practice, this "*virum probum*" assumed huge proportions, and among other wonders undertook the cure of cancers—gravely attending daily upon cases in the last stages, and sapiently dressing the ulcerated surfaces with a solution of carbolic acid, and applying fresh bandages. The following are specimens of his prescriptions:

1. ℞ Port vinum.....4 oz.
Dr. ——

2. ℞ Liquor potass iodid.....80 minims
Potass iodid.....16 grains
Iodid puri.....3 grains
Syrup flui auratium.....2 oz.
Half-teaspoonful 3 times a day. Dr. ——

3. ℞ Calomel.....2 grains
Santonin.....10 grains
Divide into 2 powders, and give one night and morning. Dr. ——

The following prescription was one which he greatly lauded. It was French, and was ordered for a woman in the last stages of phthisis pulmonalis:

4. ℞ Pure creasote.....10 parts
Compound tincture gentian...30 parts
Alcohol.....150 parts
The whole to measure one pint.
Dose.—One to five tablespoonfuls. (!)

If the poor lady for whom the prescription was ordered took a tablespoonful, which was the minimum dose (which was allowed to pass by the druggist), she swallowed creasote, 12½ minims; comp. tincture of gentian, 38 minims; and alcohol, 3 fluid drachms, 9 minims. Had she taken the maximum dose ordered, she would have received a draught containing about 63 minims of creasote, 3 fluid drachms of compound tincture of gentian, and 2 fluid ounces of alcohol.

It is needless to add that the dose taken caused great burning in the throat, and it is fearful to contemplate the misery that would have followed the ingestion of the larger quantity.

With reference to this man's prescriptions of santonin, I do not know what were the ages of the children to whom they were given; but as I was informed by the parents of some that their doctor was "death on worms," and also on the patients, I infer that the amount exhibited was much too large. This opinion is also sustained by an analysis of the papers. Prescription No. 3 calls for five grains of santonin, night and morning—ten grains within about twelve hours. Another of his prescriptions ordered twenty grains in twelve hours. Estimating the ages of the children at from five to ten years, we can easily agree with the parents that the medicine was "too strong."

Whatever may be the merit of the average student, graduated after attendance on two courses of lectures, with the period of study often less than three years, the above case is sufficient to arouse inquiry why this haste to dismiss youths only half equipped for their serious and responsible work? The crowded rooms of some medical schools would seem to indicate that it is to make room for the fresh recruits who throng their doors.

However humiliating the defects of the raw disciples may be to the scientific brothers who have toiled long and anxiously to fit themselves for their responsible duties, the methods employed by the fresh aspirants to gain notice and patronage are equally obnoxious and lamentable. Practices at variance with established codes of ethics are resorted to, and *esprit de corps* seems to be quite lost sight of. These are the doctors whose patients are afflicted with most difficult and fatal diseases; who declare that to be diphtheria which to the eye of honest practitioners is herpetic sore throat, or simple angina; who diagnosticate gout as senile gangrene, and ephemeral fever as typhoid fever; who frequently declare their patients at the point of death, and needing the most assiduous and constant attention, so that when recovery takes place the physician may be glorified—nay, may even glorify himself—and, like the frog in the fable, swell himself to vast dimensions.

With such gaseous inflation the aspiring doctor's popularity soars for a season, and when its means of expansion are exhausted, it sinks and dies, only to be succeeded by other bubbles of a similar character. Sufferers following these misleading pretenders are like other silly mortals who follow *ignes fatui*, which they never reach, and which are unsubstantial and elusive in their nature.

FORMS OF MALARIAL FEVER OBSERVED IN ELEVATED REGIONS; WITH REMARKS ON THE COMPARATIVE UTILITY OF PREPARED LEMON-JUICE AND QUININE IN THEIR TREATMENT.

BY L. HUBER, M.D.,

ROCKY FORD, COLORADO.

The following cases are elaborated from notes recently taken, and present some interesting facts. The remarks upon the therapeutic agents, mainly relied upon in the treatment of these malarial diseases, are not generalized from these few cases, but embody the results of several years' experience with them, in the treatment of allied forms of fever. The use of prepared lemon-juice is not a new practice with the writer, and what he says embraces no hasty conclusions.

For convenience, the fever forms herein described are classified under two heads: *Irregular* forms and *continuous* types.

I. Irregular forms of Malarial Toxæmia, simulating spinal disease.

James D——, adult, has complained repeatedly of a more or less sudden attack, in which the muscles of the back of the neck, of the back itself and of the lower extremities would become rigid and painful. Simultaneously there would be fever symptoms, as burning of the skin, flushing of the face and injection of the eye. All these symptoms would develop daily at or about 6 P.M. During the night, and usually about 1 o'clock in the morning, there would be a copious perspiration.

When Mr. D—— applied to me I found his temperature sub-normal (97.3°), his pulse feeble, his tongue coated, his skin clammy and saffron-hued. It was in the morning, and I asked him to present himself in the evening, which he did, when I found the symptoms first described. His temperature was 102°, and his pulse 90. The midnight following, there was a copious sweat.

This periodicity of symptoms suggested strongly the malarial origin of his disorder; though he had not been out of this locality for a long time, where the elevation is 4000 feet above sea-level, and where there is a remarkably dry soil. Having been given quinine in full doses for over a week, I concluded to administer a remedy which deserves to be brought more fully to the notice of the profession, viz.: *prepared lemon-juice.* Note that I say *prepared lemon-juice.* Nearly every physician has some vague notion of the value of lemon-juice in the treatment of malarial toxæmia; there are few, however, who have any definite and adequate idea as to its best method of administration.

What I directed Mr. D—— to do applies to nearly all the cases which I think amenable to prepared lemon-juice. I ordered him to slice a good sized, fresh lemon into three pieces, rind and all, and after placing the fruit thus divided in a quart of water, to boil the quantity down to one-fourth of a quart, strain the syrupy liquid, and when cold, take it in a single dose. The best time for administration is early in the morning, upon an empty stomach. I rarely order more than one dose a day. Sometimes shortly before the evening meal I direct a second and smaller quantity to be taken.

This agent, thus prepared and administered, is highly efficacious in obscure and obstinate cases of malaria. With me it has become more popular than quinine, and has in many instances proved its usefulness. It is not an acid remedy, as many suppose, but an alkaline one. Some of its virtue must be due to the citric acid it contains, and this agent is broken up in the blood and converted in one or another salt.

To secure the highest efficacy of this antiperiodic requires persistency in some cases. It is my habit to keep up the daily morning dosage for a week. If the hepatic functions are deranged and tardy, I often precede its use with a mild laxative made of compound colocynth powder and nux vomica.

Allied to the case just described is that of Mrs. G——. I was summoned hastily to this patient one evening between 7 and 8 o'clock. I found her in more or less distress, complaining of pain in the back of the head, and in the neck, back and arms. Her speech was hesitating and slow; there was considerable motor excitement, confined mainly to the muscles of the upper extremities and face. The pulse was irregular and not, on an average, over 40; her temperature was subnormal (96.2°). I ordered a mustard bath for her feet, and mustard poultices over the back of her neck. Regarding the case as one of sudden congestion of the base of the brain and upper portion of the spinal cord, in which region a heavy dull pain was complained of, I had administered small but frequently repeated doses of ergotin and belladonna. In a reasonably short time the symptoms improved; and, by pushing the measures whenever the symptoms seemed about to recur, the patient was kept in a fairly comfortable condition. The next day the following pill was given:

℞ Quiniæ sulph.....℈j
Ergotin.....gr. iij
Ext. belladonnæ.....gr. ij
M. Ft. pil. No. x. Sig.—One every two hours.

Mrs. G—— then improved still more, and went about her usual pursuits. After several days she consulted me again, complaining of flushing of the face, headache and extreme nervousness. These symptoms regularly recurred about midday. I asked to see her about that time, which was allowed; and, in confirmation of my suspicion, I found, with other indications of a mild malarial paroxysm, a pulse of 93 and a temperature of 101.5°

This case becomes all the more interesting when the history of a previous accident to Mrs. G—— is related. Five years ago, while riding on horseback, the animal became unmanageable and pitched so severely that Mrs. G——'s impact with the saddle fractured the coccyx. Caries set in, and the case was terminated by a removal of the last segment of the vertebra. During this time she suffered from some degree of traumatic spinal meningitis, and later from excessive spinal irritation. However, for several years these conditions had improved, and she considered herself practically well.

After discovering what I strongly suspected to be a malarial paroxysm, I concluded to put Mrs. G—— on prepared lemon-juice. This was done, and with the happiest result. All the symptoms disappeared: the fever, headache, motor disturbance and general nervousness. With this direct and perfect eradication of all the outward signs by an agent known to possess anti-periodic qualities, but not known to have any virtues for symptoms having a different cause, I concluded that Mrs. G——'s case was simply another example of the irregular malarial fever more or less common to high altitudes.

This brings me to a point that I will mention, but not discuss, namely, that in Colorado and adjacent elevated countries the malarial poison is prone to affect the nerve-centres, more especially the spinal cord. It is my opinion, deduced from a series of observations, that so-called mountain-fever is a type of malarial fever, in which the poison implicates the spinal cord and the base of the brain. It is my belief, moreover, that quinine has few specific qualities for this type of fever. The remedy *par excellence* is yet to be brought forward. Mountain sage has a deserved local reputation. Further experience may prove the usefulness of prepared lemon-juice for these cases.

II. Regular forms seen in adults and children; the continuous type.

Mr. B.——, a laborer, principally engaged during the summer and fall in digging cisterns, applied to me for treatment. He complained of having a chill, great muscular soreness and weakness, headache, and want of appetite. Upon examination, I found his pulse 102 and his temperature 103.5°, with evident engorgement of the liver and a thickly coated tongue, the coating pretty uniformly distributed over the organ. I put him upon 5 grs. quiniæ sulph. in a fluid drachm of extract of taraxicum, every two hours, notwithstanding the fact that he had diarrhœa at the time. By the next morning the temperature had fallen to 100.1°, and by the following evening to 99°. I then gave the quiniæ sulph. less frequently from the fact that cinchonism was becoming evident, and I added to the treatment ten drop doses every three hours of dilute nitric acid. Next day the temperature and pulse were normal, and the coating of the tongue began loosening from the tip; and the patient's spirits were good, and he expressed a desire for food. From this period forward convalescence proceeded without interruption.

Karl L——, aged 4, was taken suddenly sick at 3 A.M., with symptoms of a chill, followed by high fever. At 5 A.M. I saw him, and found his pulse 124, his temperature, 104.3°; his tongue heavily coated, except at the edges and tip, which were red. There was no complaint of pain, nor any indications whatever of local inflammation. The case was clearly one of continuous malarial fever, such as I have repeatedly seen. I ordered the following:

℞ Quiniæ sulph.,
Pulv. acaciæ..... āā gr. xxx
Glycerinæ..... .....fʒij
Aquæ.....q. s. ad.fʒj
M. Sig.—A teaspoonful every three hours.

I also gave a few moderate doses of calomel, with a little extract of hyoscyamus, to move the bowels, which were reported to have been torpid for a few days. At 5 P.M. the pulse had fallen to 102, and the temperature to 103.5°. The quinine mixture was continued, as there were no evidences of cinchonism. Milk was regularly administered. The next morning the pulse was again 122, and the temperature 104.1°. The same treatment was continued during the three succeeding days, the case remaining in the condition as already described. With this dosage of 30 grains of quinine every twenty-four hours, there was only moderate

cinchonism, the child showing only occasional deafness and passing delirium. On the morning of the sixth day the pulse had descended to 90 per minute, and the temperature to 100.5°. The coating on the tongue began to flake and disappear, and the child's expression to brighten. On the seventh day the pulse was 80, and the temperature 99°. On the eighth day convalescence began, and continued without an interruption. During all this time the skin showed no signs of moisture. The bowels had, also, to be moved by remedies.

This continuous type of malarial fever appears to present itself most frequently in children, although I have had a goodly number of cases among adults. In every instance there seems a tolerance for quinine, and the dosage necessary to produce physiological effects is out of proportion to the age of the patient.

Towards the close of these cases, a little carbonate of ammonia is often useful. In adults, I often supplement the quinine treatment with dilute nitric acid.

I have treated these same forms with prepared lemon-juice, and have had uniformly good results. I think, however, that with children, while it is a more pleasant remedy than the quinine mixture, it tends more to disturb the stomach. Owing to the amenability of those continuous forms of malarial fever to quinine, I have tried the second remedy less frequently in them than in the irregular varieties.

These cases show that the prevalent belief that malarial poison is confined to low, marshy regions is ungrounded. They also demonstrate that each section of country has its indigenous types, and to be successful the practitioner must treat what is before him irrespective of any preconceived notions.

—The Medico-Legal Society of New York offers prizes of one hundred, seventy-five and fifty dollars respectively for the best, second best and third best essay on any subject within the domain of medical jurisprudence or forensic medicine. Competition will be limited to active, honorary and corresponding members of the Society at the time the award is made, but is practically open to all students of forensic medicine, as all competitors may apply for membership in the Society, which now has active members in most of the American States, in Canada and in many foreign countries. For further information regarding the competition, apply to the Secretary of the Society, Albert Bach, 140 Nassau street, New York.

Society Reports.

OBSTETRICAL SOCIETY OF PHILADELPHIA.

Meeting of December 8, 1887.

Dr. B. F. Baer presented the specimen and read the following report of

A Case of Traumatic Hemorrhage into an Ovarian Cyst; Operation; Recovery.

I feel warranted in presenting the specimen and relating the history of this case because of its unusual character. E. D., 45 years old, married, the mother of seven children, youngest being seven years old. She had a miscarriage two years ago. She had always, until the present trouble, enjoyed good health. In December, 1886, while engaged in re-arranging her furniture, she lifted one end of a heavy chest. She soon after became conscious of a slight pain in the left ovarian region; but she continued with her usual work. That night, however, she was awakened by a sharp pain in this region, so severe as to cause her to "bend and writhe in agony." The pain extended down the left thigh and to the back, was accompanied with nausea and vomiting, and continued with great severity during the entire night before she obtained any relief whatever. On the next day her entire abdomen had become very tender and swollen (tympanitic), but the severe pain of the night before had subsided. She gradually recovered from this attack, and was about again within two weeks; but she still had occasional attacks of sharp pain, and was treated for neuralgia. Soon after this she noticed that her abdomen was larger than usual. She had changed physicians, and was treated for "dropsy and worms" by free purgation. This greatly prostrated her, and caused a return of the pain and other symptoms of the first attack.

My friend, Dr. O. K. Adams, was now called, and found the patient in great agony, the pain being most severe in the left ovarian region, but extending over the entire abdomen, which was tympanitic. The thighs were flexed and her expression anxious. The temperature was 103°; on the next day it had risen to 104°. She remained very ill through the next few weeks, after which she gradually improved. When the tympanites and tenderness had subsided enough to permit an examination, Dr. Adams discovered a cystic tumor in the lower abdomen, which he correctly pronounced ovarian. As soon

as she was able to be moved, the patient was sent to me.

An examination, with the patient in the dorsal position, discovered the abdomen to be distended by a circumscribed projecting mass, which occupied a position between the umbilicus and the pubis, and was about the size of the pregnant uterus of the sixth month. It extended more to the left of the median line than to the right. There was resonance over the entire surface of the abdomen, even over the tumor on light percussion; deep percussion, however, gave a dull note. By palpation, the tumor was found to be fixed to the abdominal walls and deeply in the left pelvic region. Vaginal examination showed the uterus to be retroverted, and upon it the lower surface of the abdominal tumor. Toward the left of the uterus a nodular mass was felt, apparently connected with the lower surface of the tumor. Movement of the tumor caused the uterus to move with it. Fluctuation was elicited by bimanual palpation. I advised immediate removal of the tumor, although the patient had not yet fully recovered from the last attack of peritonitis. The temperature was still above 100°, and was sometimes 101° in the afternoon. This advice was based upon the recurrent character of the inflammation and its probable traumatic origin, such as twisting of a pedicle or rupture of a blood-vessel. Rupture of an extra-uterine gestation sac had been suspected, although signs of pregnancy had been absent. There had not been suppression of menstruation, but, since her first attack of pain, her catamenia had been very profuse, lasting from ten days to two weeks.

The operation was undertaken on March 15, 1887. An incision was made three inches in length in the usual position, and the tumor exposed. It was now found that adhesion between the cyst wall and that of the abdomen was so intimate as to make it difficult to distinguish which was the cyst and which the peritoneum. I began by separating the tumor from the peritoneal surface, hoping to find a place where adhesion did not exist; but in this I was disappointed, for the peritoneum was firmly glued to the anterior and lateral surfaces of the cyst wall, while above the intestines and omentum were closely adherent to it. The tumor was now tapped, and a thin serous-looking fluid tinged with blood was drained away. The cyst was only partially emptied, as it contained a semi-solid material which could not flow through the canula. Room had, however, been gained so that the dissection could be continued. By a careful manipulation the upper part was separated from the intestines and omentum by amputating the latter, when it was found that the lower lateral surface was adherent to the sigmoid flexure, while the base of the tumor, broad ligament and uterus were so united as to form one mass. After further dissection the cyst was drawn out, and the short, thick pedicle examined. This was found to contain masses of thick, clotted blood, both within and around it. After further cleansing and examining, this nodular mass was found to be the Fallopian tube distended at several points with clotted blood. A temporary ligature was now thrown around the base of the cyst, which was then removed. This facilitated the further dissection which was necessary to form a proper pedicle. The latter was then transfixed and tied, and the smaller mass cut away. The right ovary was healthy, and was not removed. The abdominal cavity was next thoroughly cleansed, a drainage tube inserted, and the incision closed. The patient recovered and went home on the twenty-eight day after the operation, but it cannot be said of her that she recovered "without a bad symptom." She did comparatively well during the first four days, but on the fifth day her temperature rose to 103°, although there was no pain or other symptoms of active inflammation. On the next day it was 104°. The patient now complained of pain at the seat of the pedicle, and the left leg was found to be slightly swollen. The drainage tube was now removed, although there was still some discharge through it. The bowels were moved by a turpentine enema. Her improvement after this was slow but sure, and she sat up on the eighteenth day.

Examination of the specimen, after its removal, showed it to be a thin-walled monocyst. It was quite half-filled with a fibrinous material. This was not attached to the cyst wall, and resembled coagulated blood in process of organization. The lining membrane of the cyst was smooth, except at several places where a dilated vein as large as a quill was to be seen. The knotted, irregular mass which formed the pedicle was the Fallopian tube and broad ligament. Why it was in this condition is difficult to determine, unless it was from twisting of the pedicle; but this could not be fully made out at the operation. The dilated condition of the veins in the cyst and in the pedicle, and the evidence of hemorrhage within the cyst cavity as well as around the pedicle, render it probable that rup-

ture of blood vessels from stasis had taken place.

Dr. B. F. Baer also presented the specimen, and read the report of

A Case of So-called Ovarian Abscess.

This occurred in a girl of 17 years of age, who was sent to him on Nov. 1, 1887. Puberty was established at eleven years of age, or rather she began to loose blood from the womb at that time, for she has never normally menstruated. As a rule, there would be a metrorrhagia every ten days to two weeks, sometimes lasting a whole week, but usually only three or four days. No serious trouble attended this flow except that she sometimes felt worn out, although it was not at any time excessive. At first, after puberty, the intervals were longer, but gradually decreased until she was almost constantly flowing. She had never suffered much until last August, when she was taken suddenly with pain in the left ovarian region. The pain was sharp, cramp-like in character, and came on during the day; but she was not aware of any cause for it, such as over-exertion. The attack occurred a day or two after the cessation of one of these attacks of metrorrhagia. The pain increased in severity until it compelled her to go to bed, where she remained a week in great suffering under the care of her physician. She continued in bed four or five days after the pain ceased, as the result of prostration and under advice. After this there was an interval of thirty days before the flow returned, the longest interval she had ever had. Then she began flowing again, October 2, and continued to flow regularly every day for the next thirty days, at which time she first consulted me. Examination revealed the vagina rather patulous, cervix soft and uterus occupying a position behind the symphysis pubis, where it was held by a tumor which occupied Douglas's pouch. The tumor extended as high as the superior straight, and seemed about the size of a fœtal head. It was rather elastic, apparently circumscribed and fluctuating. I prescribed gallic acid for the metrorrhagia and advised rest. At the next visit I gave the patient ether and determined that the tumor was almost certainly of a cystic character, and probably adherent to the posterior wall of the uterus, and to the pelvic tissues generally. I advised its immediate removal, because of the grave symptoms which it had no doubt produced, and because of the fear of its rupture and possibly fatal injury to the patient.

She entered my private hospital on November 22, and was operated on November 24. An incision two inches in length was made in the usual position, and two fingers introduced into the peritoneal cavity. I found the omentum adherent to the posterior wall of the uterus and upper surface of the tumor. This I dissected off, and found a tumor the size of a large orange, slightly flattened, occupying a position behind the uterus extending to the left. It was adherent everywhere, and seemed at first to be subperitoneal, but was soon discovered, after some adhesions were separated, to be intraperitoneal. The adhesions were quite firm, and it took ten minutes of careful manipulation to entirely release the tumor, which was then brought up to the opening in the abdomen by placing two fingers under it. It was next punctured with a trocar and canula, and drained of about six ounces of thick laudable pus. It was thus made small enough to readily pass through the incision. The tumor was of the left ovary. The pedicle was very small and short, consisting of the ovarian mesentery and ligament. I could readily have removed it without removing the tube, so free was it from adhesions to that organ. Indeed, the tube seemed to be entirely free from disease. The opposite ovary and tube were perfectly healthy, and were not removed. There was some hemorrhage, but it ceased after a little sponging, and the abdominal incision was closed, drainage being considered unnecessary. The patient complained of great pain after recovery from the anæsthetic, and it required three hypodermics of morphine to relieve her. There was also violent reaction. Four hours after the operation the temperature was 102°, and the pulse 148. This violent reaction was no doubt emotional, for as soon as the patient became quiet the temperature and pulse returned to the normal, and did not again show the slightest indication of trouble. Her recovery was remarkably rapid and uneventful. She sat up on the eleventh and went home on the seventeenth day after operation.

Examination of the specimen shows it to be polycystic, the larger cyst-cavity, which contained the pus, having a peculiar reddish granular-looking lining membrane. At places papillary tufts are to be seen. The smaller cysts contained a clear fluid and have a smooth lining membrane. This case is interesting because of the early age of the patient, the early puberty, the frequent recurrence of the metrorrhagia and the purulent character of the fluid contained in the cyst,

the latter condition constituting what is commonly called ovarian abscess. The term is a misnomer. True ovarian abscess probably never occurs; that is, an inflammation in cellular tissue or stroma of the ovary which results in "a collection of pus surrounded by a wall of lymph"—the surgical definition of abscess. When a pus cavity is formed in an ovary, I believe its origin can always be traced to a previously existing cystic degeneration of the ovary, the purulent formation being secondary.

Dr. J. Price remarked that tubal disease may exist in virgins, the probable cause of infection being unclean hands and instruments of an examining physician. The small drainage tubes were introduced in London by Dr. Bantock, and were of seven different lengths. A dangerous rise of temperature certainly did at times arise in some cases from emotional causes, a good example of which he thought had occurred in New York at the Woman's Hospital. A patient was operated on in one of the cottages and was doing nicely. During convalescence she was moved into the hospital much against her wish; her temperature rose immediately and she died in a few hours.

Dr. Hirst said that "emotional fever" was often observed after laparotomy. He had seen the temperature rise above 100° in an instant because he had told the nurse in the hearing of the patient that the stitches were to be removed the next day. He had seen some very extraordinary cases of emotional fever in the puerperal state, having more than once seen the temperature rise suddenly to 104° in consequence of a fit of weeping. This phenomenon was not very uncommon in the Maternity Hospital where the patients are for the most part young unmarried primiparæ.

Dr. Kelly observed that instrumental infection of a healthy woman is a very real danger to which many victims have been sacrificed. He advises aspiration in all small cystic tumors before proceeding to their delivery at the incision; in this way a certain proportion of lives will be saved by avoiding the frequently inevitable rupture with an escape of poisonous contents amongst the intestines. A systematic use of the drainage-tube is advisable, but not such tubes as are in common use. His friend, Dr. Dudley, of Chicago, uses a very delicate little tube which can be slipped in between the sutures and answers all purposes, especially when used as Dr. Kelly has long done, by leaving in a piece of twisted absorbing cotton, which carries everything up from the bottom of the tube by constant capillary attraction.

Dr. Longaker believed that many cases of diseased tubes were due to filthy instruments and careless manipulation. A case had come under his care, an unmarried woman, of undoubted virtue, suffering from bilateral disease of the appendages. Her history was that of dysmenorrhœa, for which the os had been incised. After this operation she was confined to bed for six months. Some months later she came into his hands, and was also seen in consultation by the late Albert H. Smith, who agreed in the diagnosis. The case passed out of his hands without operation. The conclusion that the operation was not done under perfect conditions is forced upon us, and also that by reason of this carelessness her condition was rendered worse than it had been.

Dr. Drysdale, in reply to a question from Dr. Baer, said that often when the ovarian cells are crowded together the fluid will have the appearance of pus. The application of acetic acid will, however, always differentiate them from pus cells. Pus and ovarian cells could exist in the same fluid, but in cases where the pus cells became in excess the ovarian gradually disappeared. A blow on the abdomen over the ovary has caused an inflammatory process which resulted in an ovarian abscess. Dr. W. L. Atlee had always drained after serious operations, but in his day tubes had not been introduced; he had used tents.

PATHOLOGICAL SOCIETY OF PHILADELPHIA.

Semi-Annual Conversational Meeting.

The President, F. P. Henry, M.D., in the chair.

Abstract of the address delivered by W. T. Councilman, M.D., on

Some Further Investigations upon the Malarial Germ of Laveran.

This organism, first described by Laveran, has been met with in every case of malarial fever which the writer has encountered. The organism is in high degree polymorphous, and ten tolerably distinct forms may be found in the blood. Some of these evidently represent different stages of development, and the connection between them is obvious. Others present such marked differences in form that no connection between them can be made out. Some of the forms are only found outside of the red corpuscles, and others are found free in the blood. The forms described

are: 1, non-pigmented, small amœba-like bodies inside the red corpuscles; 2, pigmented bodies larger than No. 1, also in red corpuscles; 3, pigmented bodies about the size of red corpuscles; 4, segmenting forms of the No. 3 body; 5, small hyaline bodies, which are formed by this segmentation; 6, a crescent-shaped body, with pigment in the centre, the horns of the crescent being often connected by a fine line; 7, round or oval bodies, which differ from No. 6 in shape only; 8, a pigmented body provided with numerous, long, actively-moving flagellæ; 9, actively-moving, free flagellæ, which are evidently derived from No. 8; 10, a pigmented body with an active, undulatory movement of its periphery. The first five forms are found only in intermittent fever, No. 4 only being seen in the blood during the chill period, and its presence is invariably connected with the chill. Nos. 6 and 7 are found in cases of malarial cachexia. The most interesting forms, and about whose parasitic nature there can be no doubt, are the bodies Nos. 8 and 9. These are generally absent in blood taken from the finger, but they may be found in any type of the disease. They are the only forms of the organism whose presence in the blood is not associated with a special type of the disease. They were found, however, in fifteen out of the twenty cases in which the blood of the spleen was examined. Of these twenty cases, twelve cases were of malarial cachexia, and eight of intermittent fever. In the twelve, they were found ten times, and in the eight cases of intermittent five times. From this it seems probable that Laveran was right in considering the flagellate organism the most important form of the parasite. The influence of quinine on the intra-corpuscular forms of the parasite is most marked. Doses of fifteen grs. t. i. d. for two days in succession were found sufficient to cause them to disappear. The effects of the quinine were not so apparent in the other forms. The crescents were apparently not diminished in number in one individual after he had taken forty-five grains of quinine daily for seven days, and sixty grains daily for four days.

Dr. Wm. Osler said the thought which had struck him most forcibly in looking over this subject was the almost perfect unanimity which has prevailed among the different observers as to the appearance of these organisms. With the sole exception of the segmented form (No. 4), Laveran and the early observers had described them all. His own observations, since the communication he had presented to the society last year, had been somewhat limited. He had, however, made a series of observations upon the blood of fishes and birds, since it has been stated that bodies resembling Nos. 1, 2 and 3 had been found in the blood of carp and some water-fowl. Prof. Baird had offered him facilities for this work at Wood's Hole, and had kindly furnished him with forty-five carp. He had failed to detect any such organisms in the blood of these. In the blood of a goose sent him from Ontario, he had found one or two pigmented bodies. It had been stated by Dr. McCallum, who sent him the goose, that the bird had malaria. However, the bodies were not numerous, nor was the temperature of the goose elevated, nor, as far as he could make out, had it chills. Dr. Councilman had not figured one body, which is very peculiar indeed, namely, a solid body in the centre of a clear space. It stains like a micro-organism, varies in size, and although the body itself does not change in form, yet there are sometimes changes in outline in the clear space surrounding it; they were somewhat abundant in one case only. One other point with regard to the clear bodies (No. 1), in five or six instances he had seen such bodies pass out from the corpuscle, remaining out and undergoing no further change of form. He was not altogether prepared to say what was the relationship of these bodies to the other bodies described. It has been claimed that similar changes can be obtained by special methods of staining the blood. The most important question is, first, to determine the relationship of the hyaline to the pigmented bodies, and the possibility that the hyaline may not be directly associated with them. He was convinced that the pigmented and segmented bodies were merely different stages. He could fully confirm what Dr. Councilman said with regard to the crescents. They are most peculiar and interesting bodies, occurring in the chronic cases and in those in which there had been no chills. Three weeks ago he had lectured on a case as one of mild typhoid fever; it had lasted eight or ten days with constant fever—up in the evening, down in the morning; slight enlargement of the spleen; no spots. His resident physician examined the blood and found what he thought were crescents. The case got rapidly better, left the hospital, and returned in a few days with a distinct chill, with crescents in the blood and a well marked remittent fever. The motile forms he had not seen nearly so frequently as Dr. Councilman; though he had not examined the blood from the spleen, they had been present in eight or ten cases. Nor had he seen free filaments nearly so often; when h

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wrote his paper he had not seen them at all. Since then he had watched the process of separation. It was out of the question to suppose that the crescents or motile forms could come from degenerations in the stroma of the corpuscle, but that the hyaline forms resulted from such changes was not altogether improbable. Further investigations were necessary to determine this point.

Dr. J. P. C. Griffith called attention to the diagnostic value of these organisms, and instanced a case when, from the indefinite history and symptoms, he was unable to make a diagnosis until after an examination of the blood, when a short course of treatment resulted in a cure.

Dr. H. C. Wood said that no one seemed to have made any connection between the crescents and the amœboid forms; they seem to differ in that these are destroyed by quinine, those are not affected. We know that malarial cachexia is cured by quinine, arsenic and iron; if these remedies have no effect on the crescents, what connection have these bodies with malaria? and what becomes of them? Do they eventually disappear?

Dr. Formad asked whether these organisms are the same as those bodies described by Hütter some twenty years ago.

Dr. Councilman said, in concluding the discussion, that Hütter described moving bodies attacking the red corpuscles, existing in all forms, and apparently almost everywhere else. These observations had never been confirmed. The point raised by Dr. Wood had always puzzled him, and for a long time he had tried to reconcile himself to a belief in two distinct diseases; but this he could not do, for always as the other forms disappear the crescents appear. He had never seen the crescents unless with a history of previous chills. He was not altogether prepared to say that quinine had no effect on the crescents, though in several cases he had given it in large doses with no results. Still, in some cases they do seem to disappear. He thought, with Dr. Osler, that the crescents could not be possibly produced by changes in the stroma of the corpuscles, though some of the other forms might.

W. E. Hughes, M.D., Recorder.

—Small-pox, which first made its appearance in Catasauqua, Pa., several weeks ago, continues to find new victims, through the carelessness of persons who visit the patients and men who convey patients to the Lehigh county pest-house. There are cases now in Slatington and White Hill. Three new cases have developed at Catasauqua.

Reports of Clinics.

Pennsylvania Hospital.

Medical Clinic—Prof. Da Costa.

Acute Pericarditis attacking a Heart with an already Diseased Mitral Valve.

This patient, a lad of 17, came to the hospital with a well-marked attack of pericarditis; but, in addition to the friction-sound and other signs of this disease, a soft, somewhat muffled systolic murmur was heard at the apex of the heart. The previous history of the case showed this valvular lesion to be one of long standing. Under treatment, the acute inflammation of the pericardium passed away, and with it the frictional rub, pain, tenderness, etc. As these gradually disappeared, the old mitral murmur reasserted itself, and was heard much more distinctly. The pericardial disturbance yielded to acetate of potash, one-half ounce being given in the twenty-four hours. The pain and restlessness were allayed with small doses of opiates. At the same time, in view of the patient's somewhat anæmic condition, ten drop doses of the tincture of the chloride of iron were given thrice daily. As the disease advanced to a favorable termination, blisters were applied over the cardiac region, followed by poultices, and the potash was gradually reduced.

Now, however, that the inflammation of the enveloping membrane of the heart has been conquered, we find that the heart itself, as a result of its old mitral disease, is in a state of dilated hypertrophy. The area of cardiac dulness is much increased, and the impulse of the heart is very perceptible. What line of treatment shall be continued here in order to keep this pathological change within bounds? Without wishing to depress the patient, something must be given to control the progress of the hypertrophic process. Five drops of the tincture of veratrum viride were ordered to be taken each evening, and the iron was continued in sufficient doses to gradually enrich the blood.

Acute Articular Rheumatism; Yearly Recurrence; the Salicylates vs. the Potash Salts.

The patient, a young man 26 years old, was admitted to the hospital December 18, 1887. His father had had heart disease, but died of some renal disorder. His mother is living and healthy. The man's personal history is most remarkable. He has never been afflicted by any other disease than rheuma-

tism, but this has pursued him relentlessly. His first attack of it, the acute articular form, occurred when he was but eleven years old, and every year without exception since then, either in the late fall or early winter, he has suffered from a return of the disease, each time with all its attendant distressing symptoms fully developed. For a number of years past he has also experienced severe dyspnœa, and much cardiac pain and palpitation. His present illness began about Dec. 12, and when he was admitted to the hospital on the 18th, his temperature was 102°; his wrists, shoulders and knees were swollen and tender; there were general pains throughout the body; and, in addition, there were considerable dyspnœa and cardiac pain. The heart's action was diffused and forcible; apex-beat found in sixth interspace, one inch to outer side of the nipple-line. Its area of dulness was increased. Soft murmurs were heard over the mitral and aortic valves.

The treatment adopted at the outset consisted in the administration of salicylate of sodium in ten grain doses every second hour until nine doses had been taken, when it was continued at longer intervals. During the ensuing two or three days the pains were lessened and the patient made more comfortable, but the decline in temperature was very slight. On the 21st it began rising again, and, though the pain and discomfort were not noticeably increased, it went up steadily until, on the 25th, it was 103°. A day later a marked to and fro friction-sound was heard, with its point of greatest intensity over the left ventricle; and, on the same day, signs of pleurisy were discovered at the base of the right lung.

Here, then, was an active development of rheumatic inflammation of these two serous membranes, the pericardium and pleura, in spite of the fact that the patient had been under the influence of the salicylate salt for several days. Acetate of potash, one ounce in the twenty-four hours, was now substituted for the salicylate of sodium; and, the pulse being a trifle weak, two ounces of whiskey were ordered during the day. Moderate doses of quinine were also added to the treatment; poultices were applied over the cardiac area; and, at night, morphia, grain $\frac{1}{6}$, and atropia, grain $\frac{1}{120}$, were given hypodermatically to secure rest. Under this treatment, with occasional blisters over the heart, the patient's symptoms underwent a rapid change for the better, and he is now fully convalescent. In the intervals between his yearly attacks of this disease, the patient had suffered more or less constantly from general rheumatic pains; he is easily affected by changes in the weather, and has to exercise great care in protecting himself against them. To modify as far as possible these manifestations of an established chronic condition, the iodide of potash will now take the place of the acetate, and will be continued for some time.

Remarks.—The lecturer considered this case particularly valuable on account of the very forcible way in which it demonstrated the utter inefficiency of the salicylates to limit the inflammatory element of this disease to the articulations. Not only do they fail to *prevent* the involvement in this process of the other serous membranes, such as those which were attacked in this case, but they exercise no influence whatever over these complicating lesions when they happen to be already developed. In both these respects he holds that the alkaline treatment with the potash salts is of infinite superiority to that by the salicylates.

He also called attention to the use of stimulants in cases of this kind, when evidences of heart failure become apparent. He gives them at such times unhesitatingly. He allows no theoretical considerations of the malevolent influence of stimulants on the inflammatory process to interfere with their administration. His first care is to steady and sustain the heart, knowing that, this being accomplished, powerful assistance will be afforded those other remedies which are acting on the existing disease, obstructing its progress and gradually eliminating it. His preference is for alcohol. Digitalis is of use in combination; but, if occasion should arise when he would have to choose between the two, he would select alcohol as being of more general applicability and of more satisfactory action. His advocacy of this system of stimulation is founded on long experience of its value, on the fact that his cases recover when so treated with much greater certainty than when it is omitted.

BELLEVUE HOSPITAL, NEW YORK.

NEUROLOGICAL CLINIC—PROF. JANEWAY.

Pott's Disease.

Professor Janeway opened his clinic on December 20, 1887, with a case of Pott's Disease, in its early stage. This patient, a man, forty years old, had spitting of blood two years ago, which recurred but once since, and that a few evenings after that date. He now presents some râles in the upper part of the left lung. Last summer he was

taken with a pain in the back upon lifting a barrel, which pain has since become persistent, and is accompanied with a certain amount of distress, slight difficulty in evacuating the bowels, and slight fever now and then. At present a jarring pain in his side, with a band-like feeling across the lower part of his chest, are superadded to the above symptoms, which have become somewhat aggravated. The examination revealed a slight impairment of the tonicity of the abdominal muscles, and a small numb-zone, corresponding to the eighth dorsal nerve upon the left side, in front; but no abnormality of the spinal column was observable. In picking up an object he does so gingerly. Jumping, or downward pressure exerted upon the spinal column, causes pain in the back. Relief is obtained on being raised from the axillæ.

Warning the students to be careful in arriving at a conclusion, Prof. Janeway cautioned them also to look with suspicion upon such symptoms as *persistent* lumbago, with slight fever. "It is in lumbago that one has also to bear in mind the probability of the existence of an aneurism or of gravel." In illustration of this point, he mentioned the case of a man who brought successful suit against the city for $25,000 damages, for injuries sustained by a fall. In this case the three expert neurologists, although agreeing that there was an affection of the spinal cord, were nevertheless of a different opinion as to the nature of that affection. One pronounced it a lateral spinal sclerosis, another a multiple spinal sclerosis, and the third an antero-lateral sclerosis. This patient called on Dr. Janeway some time thereafter for treatment, and was referred to Dr. Sayre as a pronounced case of Pott's disease. As regards treatment in the present case, Prof. Janeway proposed trying the plaster-jacket.

Aphasia.

Another patient was then presented to the class, who was a right-handed man of about fifty years of age, and represented a case of "ataxic aphasia with amnesic agraphia," the disease not being complicated with paralysis either of the face or of the extremities. He understands what is said to him, yet is unable to speak; and, though he recognizes the various objects held before him, he can only mimic their uses. When told to get a piece of chalk behind a certain box on this or that table, or to bring the book the doctor has in his hand, he seeks the one or takes the other and returns with the articles named. When requested to write his name, he does so, and correctly. He is also able to *copy* writing, but is not able to read what he has copied—not even his name when just written. When a knife is shown him, he recognizes it, which is manifest by his gesticulations; and he endeavors to speak his name, but, being unable so to do, he becomes greatly distressed. When told to write it, he hurries to the black-board, as if fearful of forgetting its name, begins the first letter or letters correctly, perhaps, becomes puzzled, then substituting one letter for the proper one, or one similar in sound or form, now erasing one and adding another, and finally either finishes the word incorrectly, or fails altogether to finish it. Smell and taste, as tested, were preserved. After much difficulty the following fact was elicited, namely, that he fell from a ladder, striking the back part of his head.

Professor Janeway thinks that the hemorrhage due to *contre-coup*, which had taken place in the tempero-sphenoidal lobe, gradually extended to the region of the lower frontal convolution, and thus caused the symptoms which are present in this case.

Syphilitic Endo-arteritis.

The patient, twenty-eight years old, presented syphilitic scars in various regions of the body and extremities. His solar reflex is preserved. He has paresis, with slight rigidity of the right leg, and a complete paralysis of the arm of the same side. The pupils are contracted alike, and there is oscillation of the pupils. The tongue is only partially protruded. The mental condition of this patient was so much impaired that it was impossible to obtain a complete history. This condition, however, was ascertained to have come on within the last ten days, and more or less gradually.

COLLEGE OF PHYSICIANS AND SURGEONS.

CLINIC FOR DISEASES OF CHILDREN—PROF. JACOBI.

Cyanosis.

At this clinic, held on January 4, 1888, Prof. Jacobi brought before the class a pale, ill-nourished child, two years and three months old, which had been afflicted with loose bowels immediately after its birth, and now presented a bluish appearance, especially of the legs and hands. Upon the mother remarking that the child never smiles, Prof. Jacobi remarked that the absence of a smile was pathognomonic of various conditions.

"A child in pain will not smile; a child ill of some disease not complicated with pain will not smile; but the smile is notably absent in those cases depending upon innutrition of the brain. This child was bluish since birth. The question is, whether this bluish appearance is temporary or permanent. Cyanosis also occurs in adults. When once established, it may become permanent or appear only under certain conditions. The distress of the patient is at times increased, and he is liable to paroxysms of dyspnœa and palpitation. Cyanosis is not due to the admixture of venous and arterial blood, but to an obstruction to the circulation. In the development of the heart in the embryo, a partition gradually arises from the lower part of the right wall, and ultimately separates the ventricular cavities. The septum auriculorum, formed about the same time but not completed during fœtal life, leaves an opening, which is the foramen ovale. The blood entering the right auricle by both the superior and inferior venæ cavæ, now takes the following course: that from the superior vena cava enters the right ventricle through the tricuspid valve; that from the inferior vena cava, after passing into the left auricle through the foramen ovale, enters the left ventricle. The blood from the left ventricle is then propelled into the ascending aorta, and that from the right ventricle into two paths—by the one, to the lungs through the pulmonary artery, and by the other into the descending aorta through the ductus arteriosus. The closure of the foramen ovale, as well as the contraction of the ductus arteriosus, takes place some days after birth. If the foramen ovale is *not* closed immediately after birth, it is said to result in cyanosis. This is *not* so. Any book giving you this information will not be recommended by me.

"This child presents a systolic murmur which cannot come from a mitral valve, but from the aorta, because the murmur has much too great an area and is heard at too great a distance. Again, a congenital heart disease is as a rule upon the right side, and acquired upon the left.

"Can we benefit the baby? Most babies die at two months, but a few live to the age of six or seven years. We can hold out no hope, and we have no remedy. We expect them to die. All we can do is to give a little digitalis to relieve the breathing, Mellin's food for the imperfect digestion, and narcotics, which are necessary, for the sleeplessness. Of the latter, opium in doses of one-twentieth of a grain at night, or, if this is not sufficient, then a single dose of a one-sixteenth, or a one-twelfth, or even one-tenth of a grain; paraldehyde in a half a teaspoonful dose, at night, dissolved in alcohol and taken in some syrup, is better than the former, as it causes no headache; amylen hydrate in an eight to ten grain dose—these three are the best."

Heart Disease and Gastric Ulcer.

This patient was a girl, fifteen years old, who had been attacked with measles at two years of age, and with scarlatina and rheumatism in her ninth year. One year ago she had dyspnœa and spitting (?) of blood, which has always been of a reddish color, and, for the last month, pain. "As we hear, this patient has had rheumatism. Children attacked with rheumatism do not as a rule take to bed. Such attacks are supposed by the parents to be caused by growth—the so-called 'growing pains.' The endo-carditis complicating this affection is present, in children, from the beginning." The examination of the lungs revealed nothing abnormal. "The child presents a systolic murmur, which murmur would be transmitted through the carotid if the seat of the trouble were in the aorta; not being so transmitted, there must be a lesion at the mitral valve, and this lesion an incompetency. Moreover, she bleeds. This bleeding may either come from the stomach or from the lungs. It is therefore important to note the color of the blood. As blood is acted upon by the various fluids of the body, as for example, in a hemorrhage occurring in the alimentary canal, it is necessarily changed in character. That coming from the stomach would be of a rusty or coffee-ground tint; that from the duodenum—escaping from the bowel—of a tarry color; whilst that from the lungs would be red. The characters, however, vary also with the amount and rapidity with which it has escaped. Hemorrhage is the result of some disease or congestive condition, induced by obstructions in the circulation. Congestion, if extensive, may give rise to a rupture, or a thrombus may form in a distant part. When such thrombosis takes place, you have gangrene or ulcerations following. The round ulcer of the stomach is of that character—that is, due to a thrombus. So it is here, this patient has a gastric hemorrhage from a mitral disease. That a hemorrhage may take place more readily in some persons than in others is due to the feebler structure of the blood-vessels—the most feeble more readily giving way. Thus it is that a blow or fall may give rise to an aneurism. A healthy artery ruptures less readily.

"As regards treatment, choice can be made of digitalis, strophanthus, or spartein. Caffein ought not to be given, since it causes congestion. Then, again, remedies having an influence upon connective tissue may be given, as arsenic and phosphorus. It must, however, be remembered that agents causing a reconstruction of the connective tissue in small doses cause destruction in large doses. I should give two drops of Fowler's solution in half a tumblerful of water, three times a day, and subsequently increase the dose to three drops."

Hospital Notes.

University Hospital.

Service of M. Howard Fussell, M.D., Assistant Physician to the Medical Dispensary of the University Hospital.

Tobacco Heart.

Of the cases of heart disease recently treated in the writer's room, at the dispensary, nine were diagnosticated as functional disorders due to the excessive use of tobacco. All the nine cases occurred in young men between the ages of seventeen and twenty-seven years.

The tobacco was used in all the cases in the form of chewing, the amount ranging from a half a pound to one pound a week. The habit of chewing was begun early in life in all the cases; in one case at the age of five years; the oldest age noted at which chewing was begun was twelve years; the average was seven years.

The symptoms complained of were palpitation, pain and dyspnœa. Palpitation was present in all the nine cases, and was greatest upon making any exertion. Irregular action of the heart at the time of the examination was noted in only one case. Pain was complained of in seven cases, and always had its seat immediately over the heart or under the sternum. Dyspnœa was complained of in only three cases, and was not excessive. Hypertrophy of the heart as evidenced by increased area of cardiac dulness was noted in two instances. In both cases the dulness extended to the right edge of the sternum. In the two cases in which hypertrophy had occurred, care was taken to exclude any other cause than tobacco. No murmurs were noted in any of the nine cases.

Treatment consisted in prescribing total abstinence from the use of tobacco, and in some cases, where this alone did not suffice, the moderate use of bromide of potassium. Notwithstanding the great length of time during which tobacco had been used, and the early age at which the use had been commenced, this simple common-sense treatment usually sufficed to give entire relief after three or four weeks. In only one case was digitalis used.

Periscope.

An Exceptional Case of Aphasia.

Sir George E. Paget, Regius Professor of Physic in the University of Cambridge, reports the following interesting case in the *Brit. Med. Journal*, Dec. 10, 1887: The patient was a clergyman of studious, temperate and somewhat sedentary habits, and of the highest intellectual powers, with singular gifts of speech, preaching, and lecturing extempore, with rapid delivery, never hesitating for a word, and yet never wanting in exactness. He worked unsparingly, writing much. His temporal arteries were prominent and tortuous. He was sixty-four years old at the time of his first seizure. He was found shortly before 8 A.M., sitting on the side of his bed, rubbing his right leg, conscious but quite speechless. After an hour he had recovered the power of saying "yes" and "no," but no other words. His right hand and arm were paretic and ataxic. After nine hours the ataxy was less marked, and he could manage to speak a short sentence. Next day his power of speech seemed quite restored, and there were scarcely any traces of the paresis or ataxy.

After this attack, he abstained for a time from work; but, on returning to it, was not so perfectly fluent in preaching as formerly. A second seizure occurred nearly two a half years after the first. This, like the first, occurred before 8 A.M., soon after his leaving bed, and before he was dressed. He was heard to fall in his dressing-room, and his wife, going to him instantly, found him unconscious and muttering; but in a few moments he completely recovered consciousness and speech. When I saw him half an hour later I found paresis, ataxia, and impaired muscular sense in his left arm. He had not the slightest difficulty in expressing his thoughts, and inquired in a tone of surprise, "Where is my left arm?" It was out of his sight, being turned back under his head on the pillow. After seven hours the ataxia was no longer perceptible, and the next day he was convalescent. After this attack he reduced his work, gave up his church preferment and preaching, but continued his writing, chiefly by dictation, on

abstruse subjects, and with force and clearness.

Passing over events which have no immediate connection with aphasia, we come to his third and last seizure. This occurred nearly three years after the second. It was a violent attack of cerebral hemorrhage, occasioning complete paralysis and analgesia of the right side, almost entire loss of sight and hearing, consciousness being wholly suspended for some days, and afterwards very imperfect. He lived three years after this attack, but never again spoke an intelligible word, except on one occasion, "Do, do," when apparently becoming conscious of his inability to move his right leg. He sometimes talked—if it may be called talking—long and earnestly, with modulation of voice and expression of face as if he had conception of what he was uttering, but in the utterances was no articulate or intelligible word. Though sight and hearing were impaired, he preserved the sense of taste. After two months sensibility was restored in the right hand, and some power of movement.

He was kept alive by skilful and tender nursing, but the right arm became contracted, and two and a half years after the last seizure he nearly died of pneumonia (left). After this his strength and nutrition failed, bedsores formed, contracture came on in both legs, most marked in the right; respiration was often of the Cheyne-Stokes type, and six months after the pneumonia he died exhausted.

The point of special interest has yet to be mentioned. This gentleman was naturally left-handed. Yet, as the narrative shows, his aphasia accompanied right hemiplegia, and did not accompany the left hemiplegic attack. In this the case differs, I think, from any yet recorded. The general fact has been that aphasia has accompanied paralysis of the preferentially used hand, accompanying right hemiplegia generally, left hemiplegia rarely, and then only in the cases of left-handed persons. In the case related, the aphasia followed the ordinary rule of right-handed persons, though the patient was naturally left-handed.

The explanation of the anomaly may, I think, be found in the fact that, though left-handed for other actions, he wrote with his right hand, and was in the habit of writing much. It was not due to any association between speaking and gesticulation, for he had not the habit of gesticulating.

The case has a bearing on the debated question whether the ordinary location of the faculty of speech in the left cerebral hemisphere be due to congenital predominance of that hemisphere or results from the education of the right hand. For my own part, I believe that both these causes have their influence. But the case is an additional argument on the side of education, and it points to writing as the most potent of these educational influences. The ordinary rule of the organ of speech being in the same hemisphere that serves for the voluntary movements of the naturally predominant hand—this ordinary rule was reversed, and the reversal is the more remarkable because the congenitally predominant hand had remained the preferential hand for all actions except writing. The habit of writing much seems the only assignable cause for this reversal. And it may be held to be an adequate cause, for the memory of words will naturally go with the movements of the hand that writes them; and the process is simplified by using one and the same cerebral hemisphere for recollecting the words and for directing the hand in setting down their symbols.

It has been suggested, and with some reason, that it might be better for us—that we should be capable of more mental labor, with less fatigue—if we employed both hemispheres instead of throwing all the work on to one. The case I have related would not support this view, for the gentleman was capable of an enormous amount of mental labor. His only relaxation was chess.

The degree in which the education and employment of the right hand for writing operate in inducing the use of the left hemisphere for speech might be tested by inquiring more particularly into the circumstances of cases of aphasia with left hemiplegia in left-handed persons. Has this ever been noticed in persons much engaged in writing?

Fracture of the Coccyx and Passage of the Segment Per Anum.

Dr. W. J. Jolly, of Waldo, Fla., in a letter to the *Medical Record*, December 17, 1887, says that he was called to see a woman on November 1, 1887, who was a primipara, twenty-one years old, and in labor. Nothing unusual occurred until the head pressed against the coccyx, which did not yield. He then applied the forceps, and delivered the woman without any trouble or laceration of the perineum. Immediately after delivery she suffered intense pain in the region of the coccyx, for which she was given an opiate. An examination discovered some displacement of the coccyx, which he corrected, supposing the bone to be fractured. The opiate soon relieved the pain, and the patient

did not suffer any more until the ninth day, except that there was some tenderness in the region of the coccyx. She had some slight pain on the ninth day, and on the tenth she passed a bone per anum and sent it to him, stating that she thought she had passed a joint of her backbone. Upon examination he found it to be the lower segment of the coccyx. The woman had no trouble afterwards.

Contribution to the Ætiology of Affections of the Middle Ear in Childhood.

Dr. E. Pins says, in the *Jahrbuch für Kinderheilkunde*, that diseases of the middle ear are exceedingly common in childhood, and especially in the first few months of life. The exciting causes of these diseases are numerous, and most of them are well known; but, in addition to those which are described in the treatises on ear diseases, the author lays stress on the following: 1. The entrance of water into the external ear during the daily bath. 2. The difficulty of keeping the nose clean in children: the secretions are apt to remain in the nose, to decompose and to set up catarrhal and putrid inflammatory conditions of the nasal mucous membrane, which spread to the middle ear. 3. Catarrhal pneumonia is very frequently attended by middle ear disease, as is well known to be case with croupous pneumonia. As regards symptoms, the boring of the head on the pillow is dwelt on as one of special importance under the first heading. The three causes enumerated are dealt with in detail with reference to their differential diagnosis and treatment.—*Edinburgh Med. Journal*, Dec., 1887.

So-called Surgical Scarlet Fever.

This is the name given by many to any eruption resembling scarlet fever which comes on after a wound or operation, whether it begins at the injured spot or at a distance. Hoffa (Volkmann's *Sammlung*, No. 292), has analyzed a number of such cases to be found in various publications, and reduces them to four categories: The first three are not true scarlatina, but (1), a simple congestive vasomotor erythema, depending on a vasomotor reflex; (2), toxic erythema, caused by the absorption of secretion from wounds or other fibrinous ferments, or it may be brought on by the use of chloroform, carbolic acid, or corrosive snblimate; (3), septic erythema, sometimes very hard to diagnose from true scarlatina—after the rash fades there is occasionally desquamation; (4), a real scarlatina, arising in the usual way from infection. To deserve the name of surgical scarlatina, such cases must have become infected after the infliction of the wound or operation, and the exanthem must have commenced at the wound. Nine cases are selected from the literature of the subject. Hoffa is of opinion that a wound predisposes to scarlatina, as it presents a larger surface for the micro-organisms of scarlatina to attach themselves to, and in this way he explains the shortness of the period of incubation which has often been noticed.—*Edinburgh Medical Journal*, Dec., 1887.

Action of Antipyrin upon Nutrition.

At the meeting of the Academy of Medicine, of Paris, December 6, 1887, Albert Robin read a paper upon the action of antipyrin upon nutrition. As a result of his researches, he states that the quantity of urine is always diminished in healthy subjects, and in acute conditions it is diminished, but variably so. In chronic conditions the diminution is still the rule. The solid matters are diminished about 10 per cent. in the normal state, and in typhoid fever still more markedly. This diminution is much more striking in chronic conditions. In cases in which the disease compromises nutrition most, the diminution is most important. Urea and the urates are dimished, both in normal and pathological conditions; uric acid he found to be increased in health and variable in disease. The chlorides were diminished three times out of four. Antipyrin, therefore, diminishes the general disintegration, and particularly the disintegration of nitrogenous materials.

As to its therapeutic indications, since it exercises a depressing influence upon all nervous activity, its use is indicated to modify nervous excitability. This explains Germain Sée's happy use of it in the treatment of pain, in headache, migraine, neuralgias, in which it really exercises an inhibitory influence. But pain is not the only manifestation of nervous hyper-excitability; there are a number of morbid conditions in which it occurs, either as a preponderating or superadded element. It is in this way that antipyrin has been able to exert an influence upon certain painful affections of the heart, and to give even some success in certain cases of angina pectoris. As to the antipyretic virtues of antipyrin, the author is very distrustful; and he thinks it particularly contraindicated in typhoid fever, as it increases the slightly soluble waste products, while it diminishes the vehicle which carries them. If this conclusion is confirmed, the name of the drug should more

properly be *analgesine* or *nervine*. When, however, it is desired to diminish organic oxidation, antipyrin will be found of frequent application.

As to its antiseptic action, he thinks this will find numerous applications, since this effect is manifest from small doses, while it is but slightly toxic. He suggests that the good results which have been obtained from its use in the advanced stages of phthisis, are due to the double action of antipyrin upon tissue changes and upon fermentation.

In the discussion which followed the reading of M. Robin's paper, M. Verneuil stated that he believed antipyrin capable of rendering very great service in the treatment of septic surgical fevers; that, at least, was the conclusion which he drew from his employment of it in two cases then under treatment, in which very decided benefit had followed the use of the drug.

Abscess of Brain; Trephining; Recovery.

Barr (*Arch. of Otol.*, xvi, 2) reports a case of this kind in a boy, nine years old, who had had an offensive discharge from the right ear for a year. Three weeks before admission into the hospital he was seized with severe pain in the affected ear and side of the head, accompanied by a hot and dry skin, and followed by vomiting and drowsiness. These symptoms continued for four days; the vomiting then ceased, but the pain and drowsiness remained. Eight days from the commencement of the symptoms he had a severe rigor, which lasted fifteen minutes. He had six rigors before admission to the hospital, and the pain and drowsiness persisted. There was a perforation in the upper part of the tympanic membrane, from which pus escaped. Firm pressure over the mastoid produced pain. Barr opened the mastoid cells by chiseling through the cortex behind the auditory canal, and injected a weak solution of carbolic acid through the antrum and tympanic cavity out by the external meatus, and also in the reverse direction. A small quantity of pus and caseous *débris* was washed out. A drainage tube was introduced into the orifice in the bone, and iodoform used as a dressing. Twice a day afterward an antiseptic solution was forced through the opening and drum in both directions. Two days later he had a rigor, and the symptoms returned. Five days later there was a sudden and copious discharge of pus from the ear. All the symptoms subsequently became worse, and ptosis of the right upper lid appeared, and it was decided to trephine the skull. The middle ear was washed out with an antiseptic solution, and the scalp and neighboring parts carefully cleansed with turpentine and methylated spirit. A half-inch disc of bone was removed from the squamous portion of the temporal, at a point an inch and a half above and half an inch behind the center of the external auditory meatus. When the dura was opened and turned aside, the brain tissue immediately bulged into the osseous cavity, and rose above its external level. A hollow needle was inserted into the brain, and, after it had penetrated about three-quarters of an inch, there was a sudden escape of foul gas, accompanied by a bubbling sound and the escape of some fluid. The needle was inserted a little farther, when pus of an offensive odor flowed out. The aperture in the brain tissue was enlarged with a forceps, and portions of necrosed brain tissue were removed. The cavity was then washed out with a saturated solution of boracic acid. Pus continued to ooze from the wound, and an aperture was then drilled into the base of the skull, just above the osseous boundary of the external auditory meatus, involving the squamo-petrosal suture. The dura mater was here intact. It was opened and the abscess reached. A stream of boric acid solution was passed through this aperture so as to wash out the cavity of the abscess, and it made its exit freely by the upper opening. The current was then reversed. Chicken-bone drainage-tubes were introduced into both apertures, and the parts were thickly covered with boric acid powder and dressed with sublimated wood-wool pads. The wounds were dressed about once a week. The softened brain tissue at the seat of the upper opening in the skull soon presented a mass of granulations, which increased in size and rose into the aperature in the bone, uniting with the layer which formed on the exterior of the skull. They two soon became blended, and cicatrization rapidly progressed. The child increased in flesh rapidly, and was at the end of six weeks quite well. Three months after his admission all secretion had stopped in the ear, leaving a dry perforation behind. A vulcanite shield was fitted over the upper aperture in the skull, the lower one having completely closed.—*N. Y. Med. Journal*, Dec. 17, 1887.

—A young woman in Kansas City has been semi-unconscious for several days, as the result of a sudden and vigorous inhalation from a bottle of hartshorn, which she supposed to be one of cologne.

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HEALING UNDER BLOOD-CLOT.

It is one of the most thoroughly rooted principles of the antiseptic method in surgery that all hemorrhage must be checked and all blood-clots must be removed from a wound before it is closed. Ligatures, torsion, compression, chemical and mechanical styptics are resorted to in order to prevent the slightest bleeding, or oozing of blood, from the surface of a wound, because some of the most distinguished surgeons regard the presence of the smallest coagulum as imperiling healing and offering a favorable soil for the multiplication of the germs of suppuration and of septicæmia. In addition to this, the use of drainage tubes has been regarded as almost indispensable to good surgery, and complicated forms of suture have been devised to prevent the presence of the smallest cavity in which blood might accumulate after a surgical operation. As recently as 1882, Von Bergmann—perhaps the most eminent German surgeon now living—delivered an address before a congress of German medical men, in which he presented with great force, and backed by his great authority, the principles we have just mentioned.

It is true that every surgeon must have observed in practice that many wounds, in which it was impossible or difficult to get rid of all clots or of all hemorrhage, did not fail to heal; that, on the contrary, they sometimes progressed without interruption to a speedy healing. But, it remained for SCHEDE, of Hamburg, to describe and recommend a method of treating wounds diametrically opposite to that founded upon a fear of blood-clots. About the middle of 1886, he published in the *Deutsche med. Wochenschrift* a paper on what he called "Healing under the moist blood-crust." In this paper he described a large series of operations, including forty resections of joints, one resection of the wall of the chest, forty-seven other bone operations, twenty open operations for club-foot, and twenty-four removals of tumors—in which he secured results as good as can be claimed for any method now known.

Such results challenge the most careful consideration, and it is interesting to know that further experience has confirmed Schede in the conviction that a blood-clot, so far from being dangerous to a wound, may be very useful to its healing. And now DR. A. SIEPMANN, of Hagenau, comes forward with a series of operations in which he followed Schede's method with the very best results. His paper, which is published in the *Deutsche med. Wochenschrift*, December 15, 1887, contains a sufficiently full account of his operations, and strongly supports Schede's claim that his method is simple, easy of execution and conducive to the comfort of the patient.

The details of Schede's method may be summarized as follows: At the conclusion of an operation the larger vessels are ligated and the wound is thoroughly irrigated with a 1–1000 solution of corrosive sublimate; then, if an Esmarch's bandage has been used, this is relaxed, and any vessels which spurt are tied, no smaller vessels being touched. After this the Esmarch tube is tightened again, and the wound is irrigated a second time. Then the wound is sutured, the sutures being placed close together at the

lower part of the wound, and at the upper part from a half to three-quarters of an inch apart. The object of placing the upper sutures so far apart is to enable any excess of blood or serum to escape; but this must not be considered a form of drainage; because it takes place at the top and not at the bottom of the wound. After the sutures are secured the wound is covered with an impervious material (protective) and the part is surrounded with antiseptic gauze and antiseptic pads, in layers, and is supported with splints and bandages, if necessary. The after treatment consists in removing an upper layer of the dressing, if blood or serum comes through it, and replacing it with a dry layer, after disinfecting the surface of the one below it.

In this method it is expected that a wound will become filled with blood; and this is found to become organized and to form the basis of a reproduction of tissue, which in some cases has been very astonishing. The progress of a large number of cases treated in this way has been as good as could have been secured by the most careful control of hemorrhage and the most perfect drainage and antisepsis; and the method is so much more convenient for the surgeon, and so much more comfortable to the patient, that it is deserving of extended trial in this country. We commend it to the attention of our readers as especially applicable to railroad surgery, as well as to the operations of resection and exsection of bones and the removal of large tumors. Its advocates in Germany lay stress upon its applicability to army surgery, a fact which is more pertinent to the conditions of European nations than to those of our own more fortunate land.

HEEDLESS TALK BEFORE CHILDREN.

Some time since, a horrible story came from the South that two children, whose parents had discussed in their hearing the details of the execution of a criminal, immediately afterward put in practice what they had heard upon their baby brother, whom they promptly hung by the neck until he was dead. And now comes a similar story from Alabama that a half-witted boy, who had witnessed the killing of animals for food, soon afterwards took his brother and sister, aged respectively four and six years, to the slaughter pen and cut their throats; after which he returned and told his mother what he had done.

These stories forcibly illustrate a wrong which is often committed by parents, in talking before them of subjects which are unfit for children's ears, and of which they are apt to think children have no conceptions. As a matter of fact, children use ideas as they use tools—audaciously and without the restraints which older persons put upon them. With tools they often injure their bodies, and with ideas they sometimes injure their bodies and almost always their minds. It is not only when they thoughtlessly carry into practice such cruel suggestions as were put in their heads by what they heard in the instances cited above, that they are led to disaster by heedless talk in their hearing; but also when they receive ideas which they apply falsely to their own experiences, and which lead to mental distress or confusion, in waking or in sleeping moments. Any one who has reflected upon his early life must recognize the fact that, waking and dreaming, children are often made unhappy, or led into sin, by what older people say in their hearing without a due regard to the way in which they may understand or apply it.

For the sake of children, then, older people should be extremely careful how they talk before them, so that they shall receive from their elders no ideas but such as are calculated to increase their happiness or improve their morals.

COLORED SOUNDS.

The statement that sound should have color may seem paradoxical; but when the fact is borne in mind that all the organs of sense are developed from the same layer of the blastoderm of the ovum—the epiblast—and that all sense perceptions are probably but translations of the mechanical impressions produced by vibration, it will not seem incredible that one organ of sense may,

within certain limits, translate the impressions it receives in the language of another organ.

There are perhaps few persons who have not noticed that certain impressions upon the tactile nerves of the skin are accompanied by distinct ideas of taste, or that certain tastes, caused by unirritating substances, are accompanied by impressions of pain. And it will not surprise those who have had this experience to be told that there are individuals who, on hearing certain sounds, have an impression of color. The fact was first placed on record, we believe, by Verga, in 1865, and has been studied since then by Lausanna, another Italian, and by Nüssbaumer and other German investigators. More recently, J. Baratoux, in the *Progrès Médical*, Dec. 10, 1887, has published an interesting paper on the subject, going over it very thoroughly and giving an admirable history of it.

This subject is so interesting that we call the attention of our readers to it in the hope that some of them may be able to contribute facts illustrative of it. We live in an age when the study of mental phenomena is assuming very important relations to science, and anything which may throw light upon the inter-dependence of different parts of the cerebro-spinal system is of a more than passing value. There is no lack of theories in mental science; but there is still room for facts. And it may be that the readers of the Reporter can contribute some facts bearing upon what is called "color hearing."

CRITICISM.

Mr. Stephen Fiske, in *The Writer*, October, 1887, discusses a phase of journalistic criticism which has no direct bearing upon medical matters, but which involves a principle as important in them as in any other. This is the principle, we may say, of rectitude. He contends that the best rule for the critic is to tell the truth, with discretion, with delicacy and with generous sympathy. To this, all right-thinking critics must agree. It is a simple rule, though by no means an easy one to observe. The opportunities of one who occupies the position of a critic are such that he is under great temptation to indulge his malice, if he be maliciously inclined, or to withhold just condemnation if he be timid, partial or mercenary.

The critics of medical journals are as human as any other class of critics, and as liable to err from simple human frailty or for unworthy reasons. But they, as well as all critics, should strive to use their office honestly, sincerely and without fear or favor. They should remember that they often control public sentiment, and can do much to secure a generous reception for what is deserving, or a proper condemnation of what is wrong or foolish. To hold the balance true is not always easy, and sometimes it is very hard. But every critic should endeavor to do this with the best judgment he has, and with a due regard to what may be excused by a good intention, even though it be marred by an unfortunate execution. The great fault of the criticism of this day is not too great severity; it is rather too great leniency, or even favoritism. Books, and papers, and men, and public performances are apt to be praised with a want of discrimination, which suggests that by no means all critics have in mind the rule which Mr. Fiske formulates. The principle of charity is stretched too far, and the critic seems to have a mind more to please the subject of his criticism than to inform the readers of it as to the real value of what he is criticising. Such a course works a double wrong: it deceives those who rely on the critic, and it encourages and multiplies the number of those who put forward work which is inefficient, careless or ill-designed.

Such critics are no friends to the general reader, although they may get the credit of being more good-natured than those who regard their office as a serious one, and think more of their responsibilities than of their comfort or gains.

—Diphtheria is reported to exist to an alarming extent in Newark, N. J.

Book Reviews.

[Any book reviewed in these columns may be obtained, upon receipt of price, from the office of the Reporter.]

TRANSACTIONS OF THE NEW HAMPSHIRE MEDICAL SOCIETY; NINETY-SEVENTH ANNUAL SESSION, JUNE, 1887. 8vo, pp. 186. Manchester, N. H.: Printed by John B. Clarke, 1887.

Judged by this handsomely printed volume of Transactions, the State Medical Society of New Hampshire is a body in which good sense and good feeling are admirably blended. The report of its proceedings, at the annual meeting in 1887, is very pleasant reading; and the papers presented are more than usually interesting. It appears that in New Hampshire the State Medical Society exercises a salutary control over the admission of men to practice, and has the power of revoking licenses for just cause—a condition of affairs which we wish prevailed in every State in the Union.

In going through this volume we began to note a few passages for quotation; but their number multiplied so fast that we find it impossible to do them justice. It will, however, be no reflection upon the merits of other papers if we call especial attention to the interesting papers of Dr. William Childs, on Thirty Years' Experience in Obstetrics in a Country Practice; of Dr. G. A. Sanborn, on Homœopathy; of Dr. W. S. Leonard, on Non-Professional Prescriptions; and to the Address of Dr. G. D. Towne before the Medical Graduating Class at Dartmouth. The latter is so full of common-sense and uprightness that it might be read with profit by all who are just entering, or who have recently entered, the medical profession.

NITROUS OXIDE; ITS PROPERTIES, METHOD OF ADMINISTRATION AND EFFECTS. By S. H. GUILFORD, A.M., D.D.S., Professor of Operative and Prosthetic Dentistry at the Philadelphia Dental College. Small 8vo, pp. vii, 94. Philadelphia: Spangler & Davis, printers, 1887.

The author of this little book does not need to justify its production by the statement in his Preface, that the last practical work upon the subject, published in this country, has been out of print for sixteen years; for it would be a very good book indeed, no matter how recent, which would make this one superfluous. It contains an admirable summary of the history, properties, effects, method of manufacture, and modes of administration of nitrous oxide gas, together with instructions in regard to the precautions to be observed in administering it, the manner of operating when it is used, and the measures to be adopted in case an accident follows its use. In addition, the author gives a good account of the legal complications to which those who use anæsthetics are liable, and the best way to avoid or to escape from them.

It is interesting to note his statement that nitrous oxide is so safe an anæsthetic that only four deaths have been attributed to its administration in this country, and that all of these were probably due to impurities resulting from imperfect preparation of the gas. In regard to the use of a combination of nitrous oxide with some other anæsthetic, such as ether or chloroform, the author has had no personal experience; but his acquaintance with the experience of other practitioners leads him to the belief that such a combination, properly made, is safe and may have some advantages over nitrous oxide alone. In this connection he expresses a very sensible objection to the use of proprietary considerations, the ingredients of which are unknown; and, under the head of "legal considerations," he says, that in case death followed the use of an anæsthetic of a proprietary or secret character the operator could hardly escape a legal penalty, because it would be justly held that his ignorance of the character of the ingredients would cause any effort at counteracting the unfavorable effects of the agent to be made blindly and unskillfully.

In reading this book carefully we have detected but three points in regard to which we would suggest an amendment, one on page 58 (*note*), where the author speaks of the recurrent laryngeal nerve as the recurrent pharyngeal; another on page 59, where we think it would be better to make some statement as to the quantity of nitrite of amyl to be used to counteract heart-failure; and the third on page 74, where the method of thrusting the lower jaw forward by pressure upon the rami, when the base of the tongue obstructs respiration, might be described and recommended.

Having said so much about this book of Dr. Guilford's, we need hardly add that we regard it as one of great value, and calculated to be of great service to all who have occasion to use nitrous oxide gas.

Pamphlet Notices.

Progressive Muscular Atrophy Beginning in the Legs. By J. B. Marvin, M.D., etc. From the *Practitioner and News*, July 24, 1886.

Report on Progress in Medicine. By J. B. Marvin, M.D., etc. From the *South-Western Medical Gazette*. 24 pp.

Recent Advances in the Treatment of Pulmonary Consumption. By Solomon Solis-Cohen, A.M., M.D., Consulting Physician to the Jewish Hospital, Philadelphia, etc. From the Transactions of the Medical Society of the State of Pennsylvania. Vol. xix. 14 pp.

De las Fracturas del Cráneo y de la Trepanación. Por el Dr. D. Enrique de Areilza, Medico por oposición y Director del Hospital Minero de Triano (Vizcaya). From *Revista de Ciencias Médicas de Barcelona*, 1887. 78 pp.

—Cases of progressive atrophy of the muscles beginning in the upper extremities are not uncommon; but cases beginning in the lower extremities are rare. Dr. Marvin's pamphlet recounts the history of an interesting example of this rarity, with a good description of the disease, as Erb understands it.

—Dr. Marvin's report on Progress in Medicine, read before the Kentucky Medical Society, June 14, 1887, contains a brief review of contemporaneous opinion in regard to bacteriology, heart disease, fever, antipyretics and phthisis. In regard to the latter he describes his own experience with Bergeon's method, which he thinks of moderate value.

—Dr. Cohen has written an excellent paper upon a subject of the greatest importance. It is true that the theme is somewhat hackneyed; but its treatment in the pamphlet before us is so sensible and, we believe, so sound, that we think no one would go amiss in getting a copy of it and studying its pages with care. The sum of Dr. Cohen's suggestions is that consumption is essentially a condition of malnutrition; and that feeding—super-alimentation—is the most important part of its treatment. He believes that Bergeon's method is of decided value under certain stated conditions. Inhalation of compressed and medicated air he thinks of great value, as also iodoform, iron and creasote, given internally.

—Dr. De Areilza's pamphlet contains the histories of twenty-nine cases of fracture of the cranium, seven of them illustrated with reproductions of photographs of the heads of the patients. In addition to the author's accounts and comments on these cases, he devotes a chapter to the subject of cerebral localization, another to the indications for trephining—in which, we think, he takes sound ground—another to the secondary effects of compression of the brain, another to the late irritative effects of cerebral traumatisms, and another to the *technique* of the operation of trephining. In a final chapter Dr. De Areilza studies the mechanism of indirect fracture of the cranium (*contre-coup*), and concludes that they are to be explained logically only on the theory of the elasticity of the skull—the bursting theory—so well advocated by Messerer in Germany, and, we may add, by Von Wahl in Russia.

Literary Notes and Queries.

[In this column the Reporter will publish short items of literary interest and questions addressed to this Journal or its readers, and answers to them, in regard to any literary matters: books, authors, places and prices of publications, etc.]

—Four new medical journals have appeared in Vienna during 1887, viz.: the "*Internationale Klinische Rundschau*," the "*Klinische Zeit-und Streitfragen*," edited by Prof. John Schnitzler; "The *Centralblatt für Physiologie*," edited by Prof. Exner; and the "*Klinische Studien aus der Hydrotherapeutischen Abtheilung der Allgemeinen Poliklinik*," edited by Prof. Winternitz.

—*The Writer* is the title of a monthly magazine for literary workers, published in Boston, price $1.00 a year. It is an admirable magazine, full of interesting and instructive matter for those who write; and we think it would be found entertaining by all who read with a literary motive.

—*Woman* is the title of a monthly magazine published in New York; price $2.75 a year. The first two numbers contain a variety of interesting reading. It is intended chiefly to chronicle woman's work, and to furnish suggestions helpful to women, in their work. The motive seems to be excellent, and so far the execution of the project has been fairly good. The character of some of the advertisements warrants the suggestion that, if the publishers desire the support of sensible and upright people, they might aim to make this journal truthful from cover to cover.

—The *Health and Home Library*, Vol. I, No. 1, has been sent to us with a request that we express our opinion of its value. It is to be published quarterly, each number to contain no less than 100 octavo pages. It is issued in Chicago; price $1.00 a year.

It is hard to judge motives, and it is possible that this venture in the already weedy field of journalism may be prompted by a motive deserving of respect. But the first fruits of the venture is an apple of Sodom—fair in appearance, but nauseous to the taste. As an illustration of the quality we may mention only an article by the editor upon "Woman, her Ailments and her Sorrows," which is disgusting, when it is remembered that the periodical containing it is addressed to the laity. We find other faults in this publication; but have not space to allude to them. As we have been asked to express our opinion frankly about it, we do so in saying that it is, perhaps, the most wretched pseudo-scientific publication we have ever seen.

—*Medical Classics* is the name of a periodical purporting to be a medical magazine, published once in two months, in New York, price $1.00 a year.

Its characteristics lead to the suspicion that it is mainly intended as an advertising medium, and published in the interests of a manufacturing company of New York. Its chief literary attractions are a set of articles on monsters, copied from a book published in 1579, and several others on matters of sexual interest. There is reason to believe that it has little circulation except what it secures by gratuitous distribution. This distribution is not limited to medical men. We happen to have learned that the issue of December, 1887, was sent to a number of lawyers in this city, unasked, and not marked as specimens, and that its contents impressed one of them so that he inquired, after looking through it, "Where is Mr. Comstock?"

—The Senate of Michigan University has adopted a memorial tribute to their late colleague, Dr. Alonzo B. Palmer, who has served the University with distinguished ability for more than thirty-five years. He had a large influence in shaping the general policy of the Medical Department, and contributed very materially to its unbroken success. It was his good fortune to see the college which had started as a feeble organization steadily develop into one of the largest and most prominent of the medical colleges of the country, and to realize that this was largely due to his efforts. Dr. Palmer contributed many essays of interest and value to the literature of medicine. He also published "Lectures on Homœopathy" in book form, and a text-book for schools entitled "Temperance Teachings of Science," which has had a wide circulation. The crowning work of his life was the publication of a complete treatise on "The Theory and Practice of Medicine," in two large octavo volumes. In the International Medical Congress, which recently met at Washington, he occupied the position of chairman of the Section on Pathology; in the American Medical Association he was chairman of the section on the Practice of Medicine.

CORRESPONDENCE.

Antipyrin—Help from the Reporter.

EDITOR OF THE REPORTER,

Sir:—I have had some apparent good results from the use of antipyrin in pertussis, used in doses of from two to five grains three times a day. My opportunities for testing the treatment thoroughly have not been sufficient. I therefore trust I may hear something further from those who read this, and have an opportunity to try the remedy.

As an illustration of how a physician may often be benefitted by a good medical journal, and just at a time when he can best appreciate it, I relate the following: A short time ago I received the REPORTER, which contained an editorial on the Hypodermic use of Strychnia in Heart Disease. At the time I read the article I was treating an old man, 60 years old, who had mitral disease, and was suffering with loss of compensation in the heart and the symptoms usually following it. I had used such preparations of digitalis as I could get, which were not the best; but irritability of the stomach supervened, and I was obliged to use hypodermic injections of morphia, $\frac{1}{8}$ grain, and atropiæ, $\frac{1}{100}$ grain, each night, in order to procure sleep and to relieve the distressing dyspnœa. As I had no suitable preparation of digitalis for hypodermic use, and as it increased the irritability when given by the stomach, I used strychnia, as directed in the editorial referred to, with great benefit; and, I believe, had my patient been placed under favorable conditions *otherwise*, I might have saved his life, or at least prolonged it.

As it was, the patient was greatly debilitated and did not take his bed until too weak to sit up or walk; he died after three weeks' illness. However, with the "hint" in the columns of the REPORTER, I was led to try the strychnia, and satisfied myself of its utility. Before using the strychnia hypodermically, I had given pellets of nux vomicæ internally.

The next number of the REPORTER, after the one referred to, contained an article on "Laparotomy in Gunshot Wounds of the Abdomen." At the very time when I received it, I saw the case of a young man with a pistol wound of the abdomen who died before an operation could be performed. The reader may term this a coincidence, but I have had similar coincidences to occur many times in the ten years I have taken the REPORTER, and often they came as a valuable relief just at a time when I had apparently exhausted my resources, and knew not where to look for another. As Dr. Bennett suggests, we want clinical reading and practical information. The city physician may keep posted on the advances of medical science by continued association with or among eminent men in the profession, and by improving the opportunities and advantages of associations; but the country doctor must look to his journals if he keeps posted; for in these days of rapid progression the text-books soon grow old, and many things that are good are replaced by something better.

Yours truly, W. N. SHERMAN.

Kingman, Arizona, Jan. 9, 1888.

A Correction.

EDITOR OF THE REPORTER,

Sir:—Is not the reference to the report of Drs. Wood and Formad, mentioned on page 721 of the REPORTER (Nov. 26, 1887), a mistake? You have it, "Appendix A.—Report of the National Board of Health for 1887." Should it not be "*Appendix No. 1.—Report of the National Board of Health for 1881.*" No appropriation has been made for publishing the Reports since that of 1885, and even if there were, that for 1887 could scarcely be issued so soon. Please correct error in the REPORTER, if error it be.

Respectfully, L. H. COHEN, M.D.

Quincy, Ill., Jan. 2, 1888.

[The error in our statement was a typographical one. The date should be 1882, instead of 1887. The correct description of the paper is "Appendix A.—Report of National Board of Health, 1882."—EDITOR.]

Artificial Eyes for Horses.

EDITOR OF THE REPORTER,

Sir:—Where is the best place to get artificial eyes for horses?

Yours truly, B. F. D.

[Our answer to this question has been unavoidably delayed. We cannot say where the best place is; but Messrs. J. Kannofsky & Co., 369 Canal Street, New York, make a specialty of this line of goods.—EDITOR.]

Pronunciation of -itis.

EDITOR OF THE REPORTER,

Sir:—What is considered the proper pronunciation of -itis in gastritis, hepatitis, etc.

JOHN HILL, M.D.

Vincennes, Ind., Jan. 11, 1888.

[Both eye-tis and ee-tis are "considered" proper. What *is* proper depends upon whether the speaker consistently pronounces his Latin in the broad English way, or not. If he does, then he may say bronch-eye-tis; if he does not, then he should say bronch-ee-tis. —EDITOR.]

Notes and Comments.

How to Make Koumiss.

The *National Druggist*, in answer to the question, "how is koumiss made?" publishes the following directions for its manufacture: Fill a quart champagne bottle up to the neck with pure milk; add two tablespoonfuls of white sugar, after dissolving the same in a little water over a hot fire; add also one-quarter of a two-cent cake of compressed yeast. Then tie the cork on the bottle securely, and shake the mixture well; place it in a room of the temperature of 50° to 95° F. for six hours, and finally in the ice box over night. Drink in such quantities as the stomach may require.

It will be well to observe several important injunctions in preparing the koumiss, and they are: To be sure that the milk is pure; that the bottle is sound; that the yeast is fresh; to open the mixture in the morning with great care, on account of its effervescent properties; not to drink it at all if there is any curdle or thickening part resembling cheese, as this indicates that the fermentation has been prolonged beyond the proper time. Make it as you need to use it. The virtue of koumiss is that it refreshes and stimulates, with no after reaction from its effects. It is often almost impossible to obtain good fresh koumiss, especially away from large towns. The above directions make it possible for any physician to prescribe it.

The Isolation of Phthisical Patients.

Dr. Brown-Séquard, says the *Med. Press and Circular*, December 7, 1887, has just been calling attention to the necessity of isolating phthisical patients, on the ground that the disease has been shown to be transmissible during grouping together of patients affected with the disease. The evil results of breathing a bacillus-laden atmosphere are perceptible, he alleges, not only in the persons in attendance, but in the patient himself, whose end is thereby hastened. For this purpose he suggests a system of ventilation, analogous to that devised to carry off the products of gas combustion, and doubtless in special hospitals something of the kind might be practicable. Unfortunately, the vast majority of phthisical people are not in hospitals, but cooped up under circumstances which conduce in every way to the progress and dissemination of the disease. The suggestion is one of those which would be valuable were it only practicable.

The International Medical Congress.

The *Medical Press and Circular*, December 28, 1887, says: The great event of the year in the medical world was certainly the Ninth International Congress, which took place at Washington, in September. The period of organization was a stormy one. A vigorous protest on the part of the medical practitioners of the United States against the exclusive privileges, arrogated to themselves by a powerful clique of the best known men in the Eastern States, led to a violent rupture, which, for a time, menaced the very existence of the Congress. Thanks, however, to the bold and concerted action of the dissentients, who had with them the vast majority, if not the most illustrious members of the profession, the reorganization was satisfactorily accomplished, and the Congress, though its lustre was dimned by the unfortunate disputes and the obstinate hostility of the defeated party, was numerically a brilliant success. So far as one can form an opinion, the scientific value of the meeting was equal to, though it cannot be said to have surpassed that of its predecessors. One great result of the abstention of the best known specialists, etc., was to bring into relief the really sterling qualities of some provincial men, who displayed a knowledge and a science very much in excess of what one might have been led to expect.

The London *Lancet*, December 31, 1887, says of the Ninth International Medical Congress: "The success of the Congress, in spite of adverse circumstances and prognostications, is a matter of congratulation."

Urine Fever and Toxic Urine.

Mr. Reginald Harrison, F.R.C.S., Surgeon to Liverpool Royal Infirmary, in the course of his Lettsomian lecture on Some Points in the Surgery of the Urinary Organs (published in the *Med. Record*, Jan. 14, 1888), lays down the following propositions, which embody his conclusions with regard to the production of "urine fever" and toxic urine:

1. That the presence of urine in relation with a recent wound is necessary for the production of what I have spoken of as urine fever.

2. That mere contact of urine with a wound is not sufficient for its production.

3. That the retention of fresh urine within the area of a recent wound is almost invariably followed by its development in a greater or lesser degree.

4. That where urine is placed under such circumstances as have been last mentioned,

the liability to the development of urine fever is greatly diminished when it is sterilized by local or general means.

5. That the retention of fresh urine, blood, and the débris of damaged tissue in the confines of a recent wound for a certain time, at a temperature of somewhere about 100° Fahr., could hardly be possible without chemical changes taking place in the constituents referred to.

6. That there is a common origin for urine fever is rendered probable by the uniformity of the symptoms attending it, which, though differing in degree, are identical, whether following a surgical operation or an accidental wound.

A Case of Cerebral Tumor.

A case of cerebral tumor, admitted into St. Bartholomew's Hospital, under Dr. Andrew, was described by Dr. Ormerod at a meeting of the London Pathological Society in December, 1887. He also showed the skull partially perforated in numerous places by the new growths. The patient, a man, was unconscious for more than a year before death, life being preserved by artificial feeding through the nose. The holes in the skull were due to small soft tumors sprouting from the brain, and a large abscess was found post-mortem in the left tempero-sphenoidal lobe.

The Conviction of Dr. Cross for Murder.

The *British Medical Journal*, December 31, says: "A most painful impression has been produced in Ireland by the conviction of Dr. Cross, a retired surgeon-major, for the murder of his wife by poisoning. The convict had a *liaison* with the governess, whom he married a fortnight after his wife's death. Mrs. Cross had been ill for over a month, and was attended by her husband, who certified that she died of typhoid fever. His subsequent hasty marriage appears to have aroused suspicion. The body was exhumed, arsenic in poisonous quantities was found, and there was no trace of typhoid fever. It was proved that Cross had bought a pound of arsenic for sheep-dipping purposes a year ago. The defence was that the deceased was in the habit of taking arsenic for her complexion, and it was suggested that a small bottle which was found in her press after her death, and which was thrown away, contained the poison. The only witness examined for the defence was the prisoner's sister. After conviction, he protested his innocence of the crime. The convict is a man of property, and moved in the best society." The doctor was executed.

Long-Lived Medical Men.

The London *Lancet*, Dec. 31, 1887, speaking of the death of medical men during the year 1887, says: "Dr. Ogston, of Aberdeen, had been teaching medicine for more than half a century; and Dr. Walker, of Peterborough, who died at ninety-one, had been "qualified" for seventy-one years. At eighty he walked by night across fen and fields to operate for hernia in a humble cottage, with the light of a tallow candle. More wonderful still was the death of Dr. Neklewitsch, of Loske, in Poland, at the alleged age of 109, having seen a patient just a quarter of an hour before."

The *Medical Press and Circular*, Dec. 28, 1887, records the death of Mr. George Sylvester, M.R.C.S., Eng., who is stated to have been the oldest medical practitioner in England. He was born March 10, 1788, consequently was within a few weeks of completing his century.

Extirpation of the Spleen.

An enlarged spleen was removed in London, December, 1887, by Sir Spencer Wells. The solid portion weighed one pound fourteen ounces, after a great deal of blood had drained from it. The patient was an unmarried woman, 24 years old. The wound healed by first intention, and she was so well on December 21 that she was expected to return to her country home before the end of the year.

The Influence of Sensations on One Another.

Under this head Dr. Urbantschitsch of Vienna reports some curious experiments, the value of which must be left to future research to decide. His general conclusion is, that the excitation of one sense-organ increases the acuteness of the others. If a disk be regarded at such a distance that its color is indistinct, the hearing of a sound will bring out the color. The beating of a watch is heard more clearly with the eyes open than with the eyes closed. Red and green increase auditory perceptions; blue and yellow weaken them. The fact that we listen to music with our eyes closed is due to other reasons, and also to the fact that the *ensemble* appears best when the tones are not at their clearest. Smell, taste and touch are open to the same influence. Red and green increase the sensitiveness of each of these senses; yellow and blue weaken their sensitiveness. Touch and temperature have a reciprocal influence. If one tickles the skin and plunges it into warm water, the

tickling ceases; if into cold water, the tickling brings out the feeling of cold. These observations are regarded as showing the same re-enforcing action between sensations as has been shown to exist between motions, and as offering a mode of explanation of those curious associations between colors and sounds so insistent in some minds.—*Science*, Dec. 30, 1887.

Philadelphia County Medical Society.

The Philadelphia County Medical Society held its business meeting and annual election of officers January 18, 1888. The treasurer, Dr. L. K. Baldwin, reported the receipts of the year as $2368.74, and the expenditures $1446.88. There are 504 members in good standing. The publication committee presented a volume of the year's transactions to each member. The expenses of the committee for the year were $728.33.

Arrangements were made for the entertainment of the State Medical Society, which meets in Philadelphia in the spring.

Frederick W. Pavy, M. D., F. R. S., and Lennox Browne, F. R. C. S., both of London, England, were elected honorary members, and sixteen others as active members.

Delegates were elected to the American Medical Association, and to the Medical Society of Pennsylvania.

The officers elected for the year 1888 were: President, J. Solis-Cohen; first vice-president, W. W. Keen; second vice-president, E. T. Bruen; secretary, S. Solis-Cohen; assistant secretary, A. C. W. Beecher; treasurer, L. K. Baldwin; censor, W. W. Welch.

The Brains of Celebrated Men.

The *Lancet*, Jan. 7, 1888, states that at the Société de Psychologie Physiologique, M. Manouvrier read a report upon the brain of the late Dr. Bertillon, the eminent statistician, and compared it with the brain of Gambetta, which had been studied by Mathias Duval and Chudzinsky. In weight Gambetta's brain was below the average, only scaling 1290 grammes (about 44¼ ozs.). That of Bertillon exceeded the usual weight, reaching 1394 grammes (about 47¾ ozs.). It is now admitted that, other things being equal, the weight of the brain is in proportion to the intelligence of the individual, and, moreover, the greater the intelligence the greater the absolute and relative development of the frontal lobes. A comparison of the brains of Gambetta and of Bertillon shows that the former is smaller, more particularly in the anterior portion, less so posteriorly, and that the temporal region is even larger. Now, the qualities of the two men were diametrically opposite. Gambetta was active and loquacious; Bertillon was reticent and retiring. Although an admirer of oratory, he had always failed as a speaker. In Gambetta's brain the circumvolution of Broca is extremely developed; in Bertillon's it is reduced to its most simple expression. Bertillon was in his youth left-handed, but he became ambidextrous later in life. The third frontal circumvolution on the right side (the speech centre of the left-handed) is larger than the corresponding one on the left side.

Freedom of Practice of Medicine in Germany

A correspondent of the *Medical Press and Circular*, Dec. 28, 1887, says: One of the burning questions of the year has been whether practice shall be free or not. But this is scarcely the whole question. It is difficult for all medical men in Germany to earn a livelihood as matters stand at present. A large number of irregular practitioners and quacks thrive, and there is a feeling abroad that, if these were suppressed by law, the money now diverted would return to its legitimate channel. Such a law could, and probably would, be passed if the profession were unanimous in demanding it; but it could not be passed alone. It would certainly carry another with it, making attendance on the sick compulsory. Any medical man, on receiving an urgent summons to visit a patient, would have no choice; the law would oblige him to go. Only those who know what the old law of compulsory attendance was have any idea of the irksomeness of it, and there has been, therefore, for some time a lively discussion as to the merits and advantages of the two systems. At present, those who are in favor of freedom of practice are in the majority; but it may be that increasing difficulty in making both ends meet will turn the scale.

Tribute to Three Brothers.

The Philadelphia *Ledger*, January 13, 1888, says: Dr. Robert Nebinger, whose death is announced this morning, is the last of three notable Philadelphia brothers. They were all noted for their intelligence, their benevolence, their public spirit, and their good citizenship; all three had been druggists first and then graduated physicians; all three were men of handsome personal appearance and fine manners; all lived to mature manhood, and yet lived and died unmarried. Dr. Andrew Nebinger, the eldest and second to pass away from this world; Dr. George

W. Nebinger, the second in seniority, but the first to die; and Dr. Robert Nebinger, the youngest and last to survive—leave memories that will be long cherished and honored.

The Action of Antipyrin in Epilepsy.

M. Georges Lemoine, in a paper on the action of antipyrin in epilepsy, sums up his conclusions as follows: Antipyrin is without action in the majority of cases of epilepsy, but nevertheless gives good results in those cases which belong to the following categories: (1) Epileptics in which the attacks are influenced by menstruation. (2) Epileptics who only have suppressed attacks. (3) Epileptics with migraine.

A daily dose of thirty grains suffices in the majority of cases, and its employment can be kept up for a long time without any danger to the patient. There is no advantage in doing this, however; because patients become habituated to its use. It should be reserved for the period when the crises occur, and is to be preferred to the bromide of potassium in the cases just indicated.—*Gazette Médicale de Paris*, Dec. 24, 1887.

Printing with Reference to Eyesight.

Several of the French railway companies, and other public bodies, have resolved on having their printing done on green instead of white paper. The reason for the alteration is that they believe the combination of white paper with black characters endangers the eyesight of their work-people. Black on green has always been recognized as a good combination, and many railway tickets are so printed. —*Druggist's Circular*, January, 1888.

Benzine in Making Suppositories.

A correspondent writes to the *Druggist's Circular*, January, 1888, recommending benzine as an agent in making suppositories without the aid of heat. He rubs the medicinal ingredients thoroughly with the cacao butter and then drops benzine into the mass, a very little at a time, and is thus able to bring it to pilular consistency. Lycopodium is used for dusting and the suppositories are either rolled or gently forced into a mould. They harden rapidly. Ether may be used instead of benzine, our correspondent says, but he prefers the former.

Borate of Ammonium.

Borate of ammonium has been found by Professor Lashkevich of great value in phthisis. Internally he gives five grains three times a day in solution, either alone or combined with codeia, hyoscyamus, or other sedatives. This he finds produces a marked effect on the expectoration, and in some cases where the affection had only reached an early stage, he observed a distinct diminution of the pyrexia. The solution was also employed with advantage as an inhalation, reducing the expectoration, and alleviating irritating and painful conditions of the mouth and throat.—*British Medical Journal.*

Sulpho-Benzoate of Soda in Antiseptic Bandages.

Heckel stated before the Paris Academy of Medicine, Nov. 14, 1887, that he had found sulpho-benzoate of soda an excellent thing for antiseptic bandages. The solution employed for the bandages was of a strength of 15 to 20 grains to a pint of water.

A Useful Hair Tonic.

Castor oil	1 pint
Alcohol	1 "
Tincture of cantharides	1 oz.
Essence of bergamot	ʒij

Color with alkanet. Allow to stand for two days and filter.—*Chemist and Druggist.* (Probably any ordinary coloring matter, such as logwood, will do as well as alkanet).

Prescription for Rachitis.

The following is from the *Progrès Médical*, Dec. 3, 1887:

Phosphorus	gr. ¼
Oil of sweet almonds	fʒviiss
Gum arabic (powder)	
Sugar (powder) of each	ʒiii ¾
Distilled water	fʒxss

M.—Two or three teaspoonfuls, in coffee, a day.

Elixir of Saccharin.

A convenient fluid preparation of saccharin for dispensing purposes is:

Saccharin	grains 24
Bicarbonate of sodium	grains 12
Rectified spirits of wine	fl. drachm 1
Distilled water	fl. drachms 7

Rub the saccharin and bicarbonate of sodium in a mortar, with the water gradually added. When dissolved, add the spirit and filter. Twenty minims contain 1 grain of saccharin. This is sufficient to flavor a four ounce mixture.—*Am. Druggist.*

Eczema of the Eyelids.

Laille recommends in the *Union Médicale* the following:

℞	Acid. acetici (crystalized)	gr. iii
	Aquæ laurocerasi	fʒv
	Glycerini	♏ lxxv

M. Sig.—To be painted on daily with a brush.

NEWS.

—Small-pox has appeared in Wilmington, Delaware.

—Dr. Dixon, Professor of Botany in the University of Edinburgh and Regius Keeper of the Botanical Gardens, died suddenly, December 30, 1887.

—Dr. H. Augustus Wilson has been elected Professor of Orthopædic Surgery, and Dr. Alexander W. MacCoy, Professor of Diseases of the Throat and Nose, in the Philadelphia Polyclinic and College for Graduates in Medicine.

—Among the inmates of the Connecticut State Hospital for the Insane, at Middleton, is a man who hasn't spoken a word for twelve years, except one morning, when he remarked to an attendant: "I guess I'll throw my bait over the other side of the boat."

—Dr. John Gordon, a cousin of Lord Byron, died at Texarkana, Ark., Dec. 14, 1887. Dr. Gordon, who had been in this country for over forty years, and was a prominent Southern merchant, claimed to be the right heir to the Earl of Aberdeen.

—The Society of Medical Jurisprudence in New York city, on January 12, appointed a committee to present to the Legislature a bill making it a criminal offence to use the name of a physician as recommending the use of any patent medicine without his consent.

—A Congress is to be held at Madrid, under the auspices of the Spanish Gynæcological Society, in April or May, 1888. It will consist of three sections—obstetrics, gynæcology, and "paidopatia" (diseases of children). The general and sectional work of the Congress will occupy eight days.

—The Section on Practice of Medicine, of the New York Academy of Medicine, met at the rooms of the Academy, Jan. 17, 1888, and chose Dr. R. C. M. Page, chairman, and Dr. G. B. Fowler, secretary, for the coming year. Dr. S. De Jager read a paper on "Objections to Williams's Pneumatic Cabinet."

—In Italy, France, and Germany, a pharmacist, in addition to his responsibilities as a citizen, has others which make him a sort of public official. As an illustration of this fact may be mentioned the condemnation, by a court in Italy, of a number of pharmacists to pay a fine of 50 francs each, and to suspension from the practice of their business for three months. The cause of this heavy punishment was that when cholera broke out at Messina they deserted their posts and fled to places of safety. As each one returned he was arrested, and after trial condemned as stated.

—A Detroit druggist was recently accused of employing an unregistered assistant. The evidence was clear, a witness being ready to testify to having purchased of the assistant, in absence of the proprietor, an ounce of Rochelle salt. When sworn, however, the witness stated that he had purchased an ounce of *sugar of lead*, a poison which the law allows grocers and others to handle without restriction, and the case had to be dismissed. Why the witness swore to a falsehood we can only conjecture, unless it was simply an aggravated instance of heterophemy.—*Phar. Era.*

—It is reported from San Antonio, Texas, that a man named Calvin Pease, while blasting in a well, Dec. 28, 1887, touched off a short fuse of a dynamite cartridge, which exploded before he got out of the well. When brought to the surface it was found that one of his hands was blown off, the other badly mangled and the entire front part of his skull, from the eyes to nearly the crown of the head, carried away, leaving most of his brain exposed, but not injured. His eyes were also destroyed. Notwithstanding these remarkable injuries Pease has not lost consciousness a single minute since the accident. He eats heartily, converses cheerfully, and sleeps well, though some opiates are necessary.

—We learn from the Government Health Report that the number of cases of small-pox in San Francisco during the year 1887 was 168, and during the period from January 1 to 5, 1888, there have been 25 cases. Of these, 14 were among the Chinese. The disease was brought to San Francisco early in May by one of the China steamers, but did not prevail to any extent until November. On December 29 the disease was declared to be epidemic by the board of health. All cases, on being verified, are immediately sent to the hospital, with their bedding and clothing; the premises are fumigated, and all persons living in the neighborhood are vaccinated if possible. Vaccination offices have been opened in various parts of the city. No children are admitted to the public schools without having been previously vaccinated. Over thirty thousand vaccinations have been made at the office of the board of health during the past six months. Under the circumstances, the board of health is of the opinion that the disease will soon be stamped out.

HUMOR.

A STUTTERING SON OF HAM, whose wife was threatened with a miscarriage, rushed into a doctor's office, and in an excitable manner, demanded his immediate attention.

"What is the matter, Pompy?" queried the doctor.

"My-my-my wi-wi-wi-wife is-is a-a-a-about to-to mis-mis-mis-misconstrue."

DOCTORING A COUGH.—Wife—I am so worried about that cough of yours, John, dear.

Husband (fondly)—Don't be foolish, little one. It is a mere nothing.

Wife—It may be a mere nothing, John; but I do wish you would see the—insurance man, to-day.—*New York Sun.*

THEY HAD ASKED Dr. Sandblast, the eminent surgeon, to carve the festal fowl, and he stood over it with the carving-knife delicately held in first position. "The incision, you will observe, gentlemen," he began, dreamily, "commences a little to the left of the median line, and—oh, excuse me, Mrs. Parmalee—I thought I was in the—the—*may* I help you to a little of the femur?"

A SAD-LOOKING man went into a drug-store, and asked the druggist if he could give him something to drive from his mind thoughts of sorrow and bitter recollections. The druggist nodded, and put him up a mixture of quinine and wormwood and rhubarb and epsom salts, with a dash of castor oil, and gave it to the man; and for six months he could not think of anything except new schemes for getting the taste out of his mouth.

AN EXPERT.—"I suppose," said the stranger, as the group of tired travelers were discussing the nature of the malady from which the German Crown Prince is suffering. "I suppose I have had as much experience in the treatment of malignant and rapid throat troubles as any in America." "Ah, you are a physician, then?" "No," said the stranger, "not exactly, but for six years I was chairman of the Texas vigilance committee."—*Buffalo Journal.*

A GIRL OUT WEST accidentally swallowed a trade dollar, a few months ago. Her life was at first despaired of; but after some six weeks' treatment and the use of a powerful specific for trade dollars, a number of red sores broke out all over her body, and, when these were opened, a copper cent was found in each. At the last report eighty-four cents had been removed in this manner, and her physician was hopeful of recovering the whole amount swallowed, perhaps with interest.

A SUNDAY-SCHOOL TEACHER began his questioning at the end of the old year with the query: "Are you better than you were last year?" A good many of the little fellows had replied "Yes, sir"; but a croupy boy on the back seat had the courage of his convictions. "I hain't no better nor I ever wuz," he said, "but," he added by way of softening the harsh statement, "I got'e sorest froat of anybody in this class—I—I—I—most got dipferia."—*Youth's Companion.*

A SHREWD SPECULATOR.—Omaha man—Having a boom down South, eh? Southern man—Biggest kind of a boom; city lots selling like hot cakes.

"I am glad to hear it. Some years ago I foresaw that the South would have a big boom and I bought considerable property down there." "You did? That beats me. When was it that you concluded the South would become a centre of immigration?" "When the tariff was taken off of quinine."

OBITUARY.

DR. OBED BAILEY.

Dr. Obed Bailey died at West Chester, Pa., January 10, 1888, aged 87 years. He was a native of Chester county and a graduate of Jefferson Medical College, where he completed his student life in 1830. He practiced his profession for many years in Chester county and in Wilmington, and while in the latter place held many offices of trust and honor. He was a graduate of Yale College. He leaves a son, one of the oldest surgeons in the U. S. Army, Colonel Elisha J. Bailey, now stationed at San Francisco. Another son is Lieutenant Colonel Joseph C. Bailey, surgeon U. S. A., and Medical Purveyor, now stationed at New York city.

There have been no Changes in the Stations and Duties of Officers serving in the Medical Department, U. S. Army, from Jan. 15, 1888, to Jan. 21, 1888.

Official List of Changes of Stations and Duties of Medical Officers of the U. S. Marine Hospital Service, for the week ended Jan. 21, 1888:

C. B. Goldsborough, Surgeon, to proceed with insane seaman from Chicago to Government Hospital for the Insane. Jan. 16, 1888.

F. C. Heath, Assistant Surgeon, to proceed to Buffalo, N. Y., for temporary duty. Jan. 21, 1888.

Omitted from Previous Lists:

G. W. Stoner, Surgeon, to proceed to Wilmington, N. C., Georgetown and Charleston, S. C., Savannah and Brunswick, Ga., Fernandina, Jacksonville, and Pensacola, Fla., as Inspector. Dec. 30, 1887.

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Clinical Lecture.

ON COLD ABSCESSES.

BY PROFESSOR TERRILLON,
SURGEON TO THE SALPETRIERE, PARIS, FRANCE.

(Translated by E. P. Hurd, M.D.)

Gentlemen:—We shall take up to-day the study of an affection which you will frequently have occasion to meet in practice, and the treatment of which has made such important advances the past few years; I allude to cold abscesses.

Cold abscesses, as you know, comprise two great varieties: the *cold abscesses* properly so called, due ordinarily to a *local tuberculosis* of the cellular tissue; and the *ossifluent abscesses*, having their origin in a disease of the bone, which is almost always of tuberculous nature. The first variety will now claim our attention.

You have recently had an opportunity of observing in our wards a remarkable example of cold abscess in one of our patients, a female, aged sixty years, and for the past two years or so very feeble. This woman presented at the inferior and external part of the forearm a small rounded tumor, quite firm and resistant at first, which insensibly increased in size, and by degrees softened so as to manifest a very evident fluctuation. All this took place without apparent inflammation, without pain; the patient experienced hardly any impediment in the movements of the wrist and thumb. For a long time outward applications of tincture of iodine were made, but to no purpose. Resolution was not obtained; the same condition of things continued for several months without change. Latterly, however, whether under the influence of traumatism, or some other cause not apparent, the little tumor has been the seat of a slight inflammatory flushing.

It was under such conditions that the patient was first treated. When fluctuation was detected, a puncture was at once made in the tumor, that the nature of its contents might be ascertained; and then, by a narrow incision, the flow of pus was favored. Every day we practiced carbolic injections into the cavity of the abscess, without effecting a cure. This absence of result, despite the treatment employed, should not surprise you. We shall find in the very constitution of the abscess the cause of this want of success.

In fact, if you examine the walls you will see that the cavity is limited by a thick indurated tissue, and that, notwithstanding the previous treatment, there remain two fistulæ through which flows a yellowish, sero-purulent liquid. The peripheral swelling does not tend at all to disappear. Moreover, the local examination still shows an elongated and hard tumefaction over the radius which completely masks the subjacent bone. Pressure causes a serous pus to ooze forth.

In view of these phenomena, we may advance two hypotheses: either we have to do with a cold ossifluent abscess, or else the underlying bone is sound, and what we really have to contend with is a simple cold abscess, or, more strictly speaking, a local, suppurating tuberculosis.

To elucidate the nature of the lesion, and to enable me to act more energetically on this local disease, I made a large incision, and through this free opening I was able to explore the cavity. I have shown you that it was lined with fungous vegetations, of gelatiniform aspect, but slightly vascular, and easy to destroy by scraping. Below the abscess sac the bone was found with its periosteum

intact; everywhere, however, at the bottom of the cavity, and in the *culs-de-sac* connected therewith, the finger moved back and forth over a thickened œdematous membrane, of fibrous aspect; finally, all around, the tissues were indurated. Note, moreover, that the abscess was situated between the skin and the deep, much thickened aponeurosis; that the tendon of the palmaris longus, smooth and intact, traversed it throughout its whole length. After having opened this abscess, I removed the fungosities with a curette. I cleaned out the entire cavity, so as to expose the fibrous and whitish envelop of the sac; then I stuffed it with iodoform gauze, and surrounded the whole with a layer of absorbent cotton.

From all this, bear well in mind the mode of evolution of this tumor: first, the appearance of a tumefaction over the inferior extremity of the radius; a little later, softening of the tumor and fluctuation; then, after an insufficient opening, the production of two fistulæ, and thereupon the discovery of the fungosities lining the sac and keeping up the suppuration. Such is the ordinary evolution of cold abscesses.

Let us now study, more in detail, their anatomical characters. The histological examination of the walls shows that there has been going on in them an alteration of a quite special nature. On section of the wall, we see that it is constituted of three distinct layers: there is first the internal surface, uneven, rough, studded with anfractuosities and fungosities; little fragments become detached and fall off into the interior of the cavity and mingle with the pus which is there. This first layer is easily destroyed by scraping. It is not so with the second layer, which is composed of embryonal cells; it is more solid and resistant. The third layer is formed of a still firmer membrane, constituting a solid zone; this is the limiting membrane.

Histological examination shows the walls to be infiltrated with tubercles. In fact, upon the internal layer we find an accumulation of embryonal elements which have become caseous and surround the giant-cell, which is characterized by its multiple nuclei and the irregularity of its prolongations; and here and there we observe the capillaries obliterated. The middle layer is infiltrated with embryonal tubercles; that is to say, with little microscopic nodules, the centre of which is occupied by a giant cell, and around which are massed embryonal cells; more externally, larger cells, called epithelioid cells, complete the tubercle nodosity. These corpuscles are separated from each other by an infiltration of embryonal cells, and present themselves under the form of little round nodules, either apart or running together. Virchow has also shown that a certain number of tubercle nodules exist without the giant cell. These two layers, which I have here considered separately for facility of description, are not in reality as distinct as I have represented them; but are intimately blended. The interior of the sac is at first organized; but, by reason of the caseification of the tubercles and of their disaggregation, it undergoes softening, falls into detritus, and little by little the work of destruction invades the successive layers, and the cavity of the abscess augments.

The most external layer of the cold abscess is constituted by heaps of embryonal cells agglutinized together, but without any organization, and studded here and there with tubercle nodules. It is not rare, in this variety of abscess, to meet with anfractuosities and prolongations of the principal cavity under the form of secondary pockets (*boyaux*), which present the most varied forms and the most complex ramifications. From a clinical point of view, these prolongations have a capital importance: they explain the difficulty of cure, for they constitute just so many secondary foci which become the point of departure of new tuberculous outputs, and, consequently, of new cold abscesses.

Let us now study the relations of these abscesses with the tissues in the neighborhood. In many cases the sac is easily separable; it may be shelled out when it is quite limited, especially at the start. Later, however, are developed those prolongations of which I have spoken, which invade the muscles and tendinous sheaths. These render enucleation impossible. In other cases you will find large partitioned chambers, due to the fact that these secondary prolongations of the sac have spread and undergone development at the same time that their communication with the sac by degrees has become larger. You must then expect to find the greatest variety in the configurations of these abscesses.

As for the contents of these abscesses, these ordinarily consist of thin diffluent pus, which is almost of the nature of serum, mingled often with flaky particles formed of the detritus of the internal surface, and floating in the liquid. These flaky particles explain the difficulty which one has in evacuating these abscesses by aspiration, even though a large-sized trocar needle be employed.

The contents of these abscesses are always subjected to a high degree of tension; hence they escape with violence at the moment of incision of the walls.

If the liquid diminishes in quantity and tends to disappear at the same time that the solid elements are very abundant, we observe a variety described under the name of *caseous abscess*, the cavity of which is filled by a whitish mass, more or less thick. Lastly, in very old abscesses, there may take place a slow absorption of the solid elements; the liquid part, on the other hand, accumulates; and when these abscesses are opened, there escapes a clear liquid, sometimes charged with cholesterine. These are the cold abscesses which had undergone transformation into cysts.

You see, gentlemen, by all these details, that the appearances under which cold abscesses present themselves are multiple. It is always in reality the same affection, but the processes of evolution may be different.

Such were the most exact notions which histological examination furnished us concerning the structure of these abscesses, when a recent discovery showed us another characteristic element, having a still greater value. In the first of these abscesses, in the fungosities which line them, and even in the substance of their walls, you will always meet with the bacilli characteristic of the disease (Koch's bacillus). A careful examination, practiced after staining the elements, enables one easily to recognize these special microbes under the form of little rods. They are often difficult of discovery, and numerous preparations may be necessary to bring them well out; yet it is rare that they cannot be found, especially when sought for in fresh preparations of the fungosities of the internal surface. I have, however, seen cases where the most patient and the most minute researches have not disclosed the characteristic bacilli, first described by Robert Koch.

In this event, gentlemen, we have another criterion, which is still more absolute than the preceding, namely, the proof furnished by inoculation. You introduce into the cellular tissue, or, better still, into the peritoneal cavity of a hare, a few drops of pus, or a portion of a fungosity; soon afterward you see develop a general tuberculosis which is certain to kill the animal. This inoculation test unfortunately demands quite a long time, one, two or three months, before furnishing the proof required; but it is ordinarily very conclusive, and when the results are positive, it may be regarded as well-nigh infallible.

We shall see, when we come to treatment, what rôle is to be ascribed to those bacilli which are the real source of the disease, and alone capable of perpetuating it. We shall see that it suffices to destroy them or prevent their development, if we would arrest the course of the local disease and effect a sure cure. Now that you know the anatomical constitution of cold abscesses, I shall describe their clinical evolution. At the start, they present themselves under the form of tumors, sometimes very superficial, bunched or rounded. When they are of small dimensions they do not give any fluctuation. This variety is designated under the name of *scrofulous gummata*. At the end of several weeks, sometimes of several months, you may discover at the centre a point of fluctuation. In such cases, the growth is ordinarily slow, progressive, and takes place without provoking any pain. When the abscess undergoes softening, the skin may become perforated, and there is seen to issue by a fistulous orifice a sanious pus, charged with detritus and clotty lumps. Sometimes the termination is different; there is an absorption of the various elements of the abscess, and the cure is effected spontaneously, but this rarely happens. After opening of the abscess, when there is no longer any tension in the sac, there is no longer any tendency to extension of the lesions, but the internal surface of the abscess cavity is irritated, and the fungosities become more abundant and more voluminious. These prevent the coming together of the walls; they sometimes protrude through the fistulous orifices which continually give issue to a purulent oozing. These fungosities are but slightly adherent; they readily yield to the curette, but they invade the entire cavity of the abscess, and even its prolongations.

Despite the name of cold abscess, applied to these swellings, when their course is rapid, there may be a local elevation of the temperature of from four to six-tenths of a degree, and you will then see a slight inflammatory zone on the external surface. Sometimes the general temperature of the patient shows a slight rise. This is especially apt to be the case after a slight contusion, or when the abscess threatens to burst.

It remains for me now to indicate the treatment of cold abscesses. When you have only the scrofulous gummata to deal with, even supposing pus to have formed, but the tumor to be of little size, and the general health not to be suffering but improving, you are warranted in waiting; a cure is possible by resorption, or after one or two aspirations.

When the abscess is larger and more extensive resorption is impossible, the sac should be freely opened, for puncture by the aspirating needle or trocar, in these conditions, is generally insufficient; the liquid is, in fact, soon reproduced by reason of the want of vitality of the abscess walls. The best way, then, in these cases, is to interfere energetically, and to perform thorough ablation of the sac, as M. Lannelongué has indicated. This practice is certainly the best when the sac which limits the abscess can be readily enucleated. You then dissect out the sac, bring together again with stitches the soft, bleeding parts separated by the dissection, and put in a drainage-tube to facilitate the flow of liquids; thanks to the methodical compression of the antiseptic dressing, the tissues reunite, and the cure is soon complete. It is necessary, however, to take care to remove the prolongations of the cavity, a task often difficult of execution when the walls are thin and soft.

By another curative method, which is more particularly applicable where the sac cannot be removed in its totality (as is, in fact, most frequently the case), you open widely into the abscess and scrape the internal surface of the sac with a sharp spoon or cutting curette, taking care to destroy the fungosities; then the two surfaces are brought together with a stitch or two. If reunion seems impossible it is better to stuff the cavity with iodoform gauze, and protect the whole by an absorbent dressing, as I have done in the case of our patient. The cure is slow, but sure.

A third method consists in making a free opening and cauterizing thoroughly the sac with the thermo-cautery in order to destroy all the fungosities. You have then nothing but a large eschar, formed by the diseased parts thus profoundly modified. This method is slower, less active, and less energetic; therefore, I will only counsel it in a restricted number of cases. At the same time, the employment of the thermo-cautery has given me excellent results in a special variety of multiple cold abscesses, many instances of which I could cite, occurring in the fold of the groin, in the axilla, neck, etc. They present themselves under the aspect of little violaceous masses with numerous holes, giving to the region the appearance of a ball-sprinkler. In those cases where there exist multiple abscesses, diverticula, detachments of tissue, and fistulous tracts extending in different directions, total ablation is impossible, and curetting, which is ordinarily incomplete, has no efficacy. It will be necessary, then, to open up all the fistulous tracts, cauterize the fungosities, transform the multiple diverticula of the abscess into a sloughing surface, and bring into full view all the detached shreds of tissue. In this way only will you obtain complete cure.

The different modes of treatment which are now everywhere in fashion, and are absolutely safe, owing to the employment of Lister's method, and especially of the iodoform gauze with which the abscess cavity is stuffed, are likely to be in a measure superseded by a method lately devised by Mosetig-Moorhof, of Vienna, and recommended in France by Verneuil. This new method is chiefly applicable to large abscesses with huge pouches, in which a radical or bloody operation seems difficult or dangerous. Starting from the principle that iodoform is an excellent parasiticide, which prevents the development of tubercle bacilli, the Vienna surgeon conceived the idea of putting this substance in contact with the walls of the cold abscess, and in such a way as to attack the microbes in their innermost haunts, and to do this thoroughly and permanently. To attain this result, it is necessary to empty the abscess as thoroughly as possible with an aspirating trocar, and wash out the cavity with a solution of carbolic acid, in order to remove the caseous particles which may be too thick to run easily. After evacuation of the sac, a variable quantity (according to the size of the cavity) of ether is injected, holding in solution iodoform in the proportion of five per cent. The quantity of the liquid thus introduced in the largest sacs ought not to exceed four ounces, for fear of accidents which might result from the absorption of too great a quantity of iodoform. The liquid is allowed to flow out after a few minutes, but a certain quantity remains in the cavity. The surface of the latter is soon lined with a thin layer of iodoform. Under the influence of this agent the pain is moderate, and the reaction not severe; but the sac soon fills again with liquid and with gas, swells and becomes slightly painful. After a few days all irritation is allayed, and we see the liquid undergo resorption, and the cavity and the tumor growing smaller. One may, in some cases, obtain a complete cure after several weeks, often as the result of a single injection. When one injection does not suffice, the operation may be repeated after a month or six weeks; two or three suffice for the largest sacs.

You will find upon this subject important particulars in the writings of Prof. Verneuil, and especially in the monograph of one of

his pupils, Dr. Verchère, which was published in the *Revue de Chirurgie*, for 1886. I need only refer you for an example of this kind of surgical intervention to a patient, A. B., of this hospital, on whom I have practiced these injections.

This patient, a woman, aged seventy-seven years, large, lean and infirm, had on the anterior and inferior aspect of the right thigh, an immense cold abscess. It was thirty-five centimetres long, twenty-three wide, and contained four quarts of grumous pus. A first injection of three ounces of ether-iodoform solution caused but little reduction. After one month the abscess had diminished one-half. A new injection of two ounces produced a similar result.

At the present time, four months after the first injection, the abscess is barely as large as half a mandarin orange, and will, I think, continue to undergo decrease till it disappears.

This is, then, an excellent method, and not dangerous, generally succeeding; and I cannot too highly recommend it to you, for I have employed it several times with success.

Communications.

THE HYGIENE OF PHTHISIS.[1]

BY LAWRENCE F. FLICK, M.D.,
PHILADELPHIA.

In the beginning of the present century Dr. Willan, in his statistics on the diseases of London, gives the percentage of deaths from consumption in his private practice as about one in three; and says that the proportion in the general mortality reports for the winter months at that time varied from one-third to one-half. In 1880 the percentage of deaths from phthisis in England was 9141 in every 100,000, which indicates a marked improvement. This improvement is not due to a larger number of cures, but to a more successful prevention which follows in the wake of civilization.

It is scarcely disputed by any one at the present day that consumption is due to the bacillus tuberculosis. Concomitant with this doctrine is necessarily that of its contagiousness, and whoever accepts the one must accept the other. Heredity ought to be out of the question at the present day. It is an unreasonable theory, and at variance with all modern knowledge about the etiology of disease. Its complete eradication from the public mind is one of the first steps necessary in a sanitary crusade against phthisis. So long has it held sway, and so thoroughly has it been woven into our literature, into our ways of thinking, and even of acting, that it has actually become a remote cause of the disease. Men and women are daily dying victims of consumption, because they have not the courage to escape its clutches. Their grandparents or parents, their uncles or aunts, or somebody in their families has died of the disease, and it is a foregone conclusion that some day, sooner or later, they will die of it too. They are tabooed by society as foreordained victims, they are refused life insurance on the slightest pretext, and are at a discount in the marriage market unless heavily endowed by purse or landed estate. Their lives are one continuous worry lest the disease overtake them, and yet they do nothing to avoid it, or the depressing influences which lead to it. If they do finally succumb to the disease, their education and that of the public have been factors in its production. Somewhat akin and often confounded with heredity is the doctrine of predisposition. That some families are more apt to develop certain diseases than others is beyond dispute. What this predisposition consists in, and whether dependent upon the blood, the nerves, or tissues, is as yet one of the hidden secrets of nature. It is certain, however, that it can be transmitted for generations, and that, like complexion and features, it may go to only certain members of a family, may skip a generation or two and reappear, or may disappear entirely. It sometimes goes with one or the other sex, and sometimes accompanies certain complexions and features. Whilst it often exhausts itself by the laws of survival, it may also be generated *de novo* by the modes of life and habits of the parents. The tight-lacing girl, the pale-faced, dissipated young man, the overworked store girl and factory hand, the tea-drinking servant girl, the drunken father, the half-starved, badly clothed mother—these are some of the progenitors of predispositions of phthisis.

So much in brief about the theories on the etiology of consumption. Their consideration has been necessary in order to study intelligibly the means for its prevention.

Both in theory and practice we find that consumption, though contagious, is but mildly so. This is, in my estimation, not so much due to inefficiency of the bacillus tuberculosis as to the withstanding power of the lungs

[1] Read before the Philadelphia County Medical Society, January 11, 1888.

of most people. The bacillus tuberculosis never finds a nidus in a healthy lung—by healthy, I mean not only freedom from pathological change, but a strictly physiological condition in which every function is properly performed. Like the brain, I believe the lungs may be functionally abnormal, and yet there be no pathological change discoverable. There is a very close relationship between the functional abnormality of the lungs and the digestive apparatus, and, in a sequential way, the whole nutritive system. It is upon the stomach, then, almost as much as upon the lungs, that much depends in the prevention of phthisis. The stomach is usually the first traitor in the human economy. Through its derangement many diseases gain entrance into the body. When the stomach fails to perform its work, the lungs will soon do the same. A vicious circle is established, and they mutually derange each other. Malnutrition follows, and the lungs become a proper soil for the bacillus tuberculosis. Every care should therefore be taken to keep the stomach healthy, and to do this a sufficient and proper supply of food is necessary. Too much food is as injurious as too little, and improper food worse than either. When the stomach is filled with indigestible food, nutrition is not only withheld, but the stomach is unfitted for the proper performance of its work for some time thereafter.

It is generally in overfed and improperly fed people that we have what is called galloping consumption. Though apparently well nourished, their entire appearance is suggestive of too much foreign matter in the blood. It is from this class of people that the mortality list from consumption is kept so high in America, and it is chiefly the foreign element in our population which constitutes the class. The deaths from consumption in the United States are nearly twice as numerous among the foreign population and their children as among the children of the native born. In Rhode Island, according to the health reports of that State for 1880, one person in every 486 of native parentage dies of consumption, while one in every 286 of foreign parentage dies of the disease. According to the United States census reports for 1880, out of every 1,000,000 deaths, 242,842 males and 302,046 females die of consumption. This represents all nationalties and colors. Among the colored race every million deaths represent 248,179 males and 326,973 females as having died of consumption. Among people of Irish parentage 309,507 males and 375,636 females die of consumption to every one million deaths; and among people of German parentage the victims of the disease number 249,498 males and 254,958 females to every one million deaths. It will be seen that the largest percentage of deaths from the disease is among Irish immigrants and their children. This is usually ascribed to the change in climate. Ireland has a much damper climate than America, and therefore one better suited to the development of phthisis. The real cause for the larger mortality from consumption among foreigners, and especially among the Irish, is the change in diet. At home they have been accustomed to a plain, healthy diet, and when they come to this country they at once take to the varied heavy diet of Americans. Where they have eaten little meat at home, they eat it in profusion here. Where they have drank good milk and eaten vegetables at home, they drink teas and coffees and eat spiced food here. They soon become thorough Americans in their stomachs, and even outdo the natives. The consequences are indigestion, malnutrition, tuberculosis. The German, though frequently pursuing a similar course, is often spared by his characteristic thrift and economy. He partakes more sparingly of the good things that come in his way, because of his anxiety to prepare for a rainy day. His fondness for beer, a beverage which he manages to secure wherever he goes, may likewise have some influence in shielding him against phthisis.

Sufficient fresh air, sufficient food, and sufficient rest and sleep are the watch-dogs of health, and where they are on the alert consumption can never enter. Bacilli of tuberculosis may permeate the air, but they can do no harm. Could civilization reach such a stage of perfection as to make it possible for every human being to have all these, it would be in the power of everyone to avoid phthisis. Such a condition of things is, however, impracticable. It therefore becomes necessary not only to deprive the bacillus tuberculosis of its proper soil, but also to destroy the bacillus. This function belongs as well to the State as to the individual. Modern governments are beginning to appreciate the importance of preserving the health of their people, and are everywhere establishing health boards. As yet, however, they do not go far enough. Medical science has grown beyond the mere art of prescribing remedies; it has become a science of protecting man against disease and enabling him to attain his three score and ten. As government exists for the good of society, it ought to avail itself more extensively of so powerful a means to its end. The medical profes

sion should be represented in our government. There should be a department of medicine, as there is a department of agriculture, of justice, of finance, etc. Surely human lives are as valuable as those of dumb brutes, and we want protection as much against the invisible foes which threaten our health as the visible ones that threaten our hearths. Unfortunately, public sentiment has not yet been educated to appreciate sufficiently the importance and benefit of sanitary measures, to make such a thing practicable. Did such a department exist, and did physicians in good standing and with scientific attainments occasionally enter the field of practical politics and allow themselves to be returned to city councils and State and national legislatures, sanitary science might shed its light upon legislation and many existing hygienic evils be remedied; many social and commercial customs and practices which are daily generating predispositions to consumption by the thousands might be corrected. Plainer living would come through proper instruction upon the subject and the instillation of the necessary sentiment in our schools. Not only ought children to be taught what to eat and drink, but also how to prepare their food and what quantity they can take consistent with health. Nor should instruction upon the proper adaptation of food to the time of life be overlooked. Many children are already dyspeptic when their school days begin, and in their cases the benefit of instruction could only accrue to the second generation. The depressing influences of private vices in children and young people could often be averted by early instruction of the proper kind. Such instruction should, of course, come through the parents, but parents are themselves frequently devoid of the proper knowledge, hence the government might supply it to them by the free distribution of appropriate books. How many social and moral evils might be warded off were the proper knowledge brought to the thousands who would gladly avail themselves of it, were it within their reach!

Legislation might in a measure protect the weak against the oppression of the strong. One need only visit the parts of large cities where the poor live, and note the crowded, filthy courts, alleys and tenement houses; or take a stroll through a badly ventilated factory or retail store in which the employés are compelled to work long hours in unhealthy positions and with the most wretched accommodations for the ordinary demands of nature; or examine some of the articles of food and drink that are openly sold in shops and on the streets, to understand what could be done in the way of sanitary science by wise legislation. The remedying of such wrongs and oppressions would very much lessen the the mortality from consumption, by withdrawing the soil necessary for its development. But all this is mere speculation of what we may hope will take place in the future. For the present, we must content ourselves with discussing the weapons against the bacillus tuberculosis, which governments can use as they are now constituted.

The usual methods employed by our boards of health for combating disease are isolation and disinfection. Against consumption, isolation, if it were even practicable, would be both useless and cruel. It is a question in in my mind whether the existence of the bacillus tuberculosis is solely for the destruction of human lungs! In view of the universality of phthisis it is not entirely a matter of fancy to suppose that the parasitic life of the bacillus in man is incidental, and that it plays some useful rôle in the great chain of transition between organic and inorganic matter. It seems to be everywhere and to be wafted about by the air. Isolation could therefore not confine it, nor afford protection. The only benefit that could be derived from it would be the withdrawal of the relatives of patients from an atmosphere saturated with the germs of the disease and their protection against contamination by the sputa. This would be a poor return for the dreadful inhumanity of separating the poor victims for years from their relatives. The same results can moreover be attained by disinfection without isolation. With well equipped thorough boards of health and properly instructed laity, satisfactory protection could be secured to those who by family ties or otherwise are compelled to live in the same house with the afflicted. The house, and especially the room, in which the patient sleeps ought to be frequently disinfected with some suitable germicide, and particular care should be taken to disinfect the sputa. For the former purpose sulphur may be burnt or a spray of a strong solution of carbolic acid be used, and for the latter carbolic acid or corrosive sublimate solution be placed in the vessel that receives the sputa. To carry out these measures in practice, consumption would have to be placed upon the list of contagious diseases returnable to the board of health, and the present force of existing boards of health would have to be largely augmented. The beneficial results, however, would be ample compensation for the inconvenience and expense. That there would be

a marked decrease in the mortality from phthisis I have not the slightest doubt. Better opportunities, too, would be afforded to study the disease, as more reliable reports would be made and fuller statistics be gathered.

Health boards should, moreover, help to disseminate proper knowledge upon the subject. If ignorance is the parent of vice, it is certainly the grandparent of disease. It is a matter of daily occurrence that people who have consumption, and who are constantly expectorating infectious matter, fill positions in which they must necessarily contaminate the clothing, food and drink of others. There are consumptive tailors and dressmakers, consumptive cooks and waiters, consumptive candy-makers, consumptive bakers, consumptives indeed in every calling of life. These people do not suspect for a moment that they are spreading the disease, and take no precaution against doing so. They are often poor people who have to work for their living, and who as long as life remains in them have to earn its support. They do not even know that they have consumption, or at least they persuade themselves that they have not got it. They expectorate on the public highways, in church, at the theatre, at their places of business or work—in short, anywhere and everywhere that is convenient; and the sputa dry up and are carried into the lungs of others, or find their way into food and drink. First of all, people ought to be made thoroughly familiar with the infectiousness of the sputa, and ought to be taught how to disinfect them. This knowledge should come from the government through the boards of health. Physicians and public teachers can do much toward creating a proper sentiment, but they cannot convey the instructions in an authoritative and effective way. In the next place, no consumptive should be employed in any capacity in which he may contaminate the clothing, food, or drink of others. To obviate hardships in such cases, the government should make provision out of the public treasury for the maintenance of such people as have to give up their means of livelihood for the public good. Whether this be done by pension or by offering an asylum must remain for political economists to decide. No hesitancy is felt in spending millions for the resentment of an insult to our national honor, or for some commercial advantage. Why should not something be expended in the protection of our people against the ravages of a disease which in the United States carries off nearly a hundred thousand people annually? Small remedies will avail nothing with so great an evil. Our government should act, and act with gigantic strides. As regards individual effort to prevent the spread of consumption, it must necessarily be confined almost entirely to those who by predisposition are likely to develop it. They should not only lead strictly hygienic lives in every particular, but should avoid everything that might even remotely lead to the disease, and avail themselves of every weapon against it. The nearer they follow Nature, in its dictates as to how to live, the better. They must not revel in excess, turn night into day, overload their stomachs, overtax their brains, strain their physical endurance, and play havoc with their constitutions generally, as their more favored brothers and sisters do with impunity. They must lead correct, orderly lives, and be ever on the alert that their physical condition may not fall below par. As regards the weapons to be used against the disease, it may be well to pass some of them in review.

Climate has always been looked upon as an important factor in the production and prevention of consumption. Its importance, however, seems to me to have been much exaggerated. A non-porous soil is undoubtedly a contributing agent to the production of consumption, but not more so than of many other diseases. Consumption occurs in every country and every climate on earth, being modified in prevalency by the various modes of life. Vicissitudes of climate have really little to do with the disease. Those people who are most exposed to the weather seldom die of consumption, whilst those whose lives keep them indoors are its most frequent victims. Women, for example, die much more frequently of the disease than men. Nor does warmth or cold or altitude exert much influence. The colored people, who live largely in the warmer portions of the United States, have a higher mortality rate from consumption than the white people, the majority of whom live in the colder portions. In short, consumption prevails everywhere, no matter what the climate, where people are compelled, by the demands of society, to crowd together and live much indoors. The practical lesson to be drawn from these facts is that persons who are predisposed to consumption by reason of the lives of their forefathers, or the peculiar circumstances surrounding their childhood, ought to adopt a calling in life which keeps them out of doors and away from cities.

There is a popular belief that alcoholic drinks are powerful preventives of consumption. This, like all popular beliefs and superstitions, has undoubtedly some truth for its foundation. But, as is usual with the bastard progeny of desire, this grain of truth has grown into such immense proportions as to have become the stumbling-block of many. No one who has carefully studied consumption can have a doubt that there exists some relation between its production and the non-assimilation of hydrocarbons. Very many cases of phthisis have traces of sugar in the urine, and probably all of them have indigestion of heat-producing food. These symptoms frequently exist for months before cough and discernible local congestion sets in. As beverages containing a small amount of alcohol present a most readily assimilating form of the hydrocarbons, they no doubt, when properly used, buoy up the weakened system in its struggle against the bacillus tuberculosis, and often enable it to gain the mastery. But what is good in moderation is always hurtful in excess, and in this instance precipitates the very evil it might otherwise prevent. Excess of alcohol and the adulterating ingredients in alcoholic beverages derange the stomach, and thus by interfering with nutrition predispose to consumption. In this way a long life of hard drinking sometimes ends in phthisis.

A very noticeable fact in the mortality statistics of consumption is the predominance of women among its victims. This is in a measure due to their indoor life, but not altogether. The many accidents and diseases incidental to the physiological life of women greatly predispose to consumption. These are, however, nearly all of an avoidable character, and have their fountain-head in carelessness during the menstrual period and during the puerperium. Women should be taught from childhood that these are sacred epochs, and that during them nature demands rest and especial care. The Semitic six weeks' rest after childbirth is true to nature, and should be observed by every woman who becomes a mother. Lactation frequently predisposes to consumption, but usually in those cases which have made bad recoveries after confinement, and are in want of the proper food and care which are necessary for a nursing woman. Pulmonary gymnastics are powerful weapons against phthisis, and should be especially used by those who are unable to extricate themselves from the unhygienic surroundings and circumstances in which their necessities have placed them. Though the use of a gymnasium is very desirable for practicing these, it is not necessary. The principle involved is ventilating the unused air-cells, and any combination of forced respiratory movements that will thoroughly inflate the lungs will accomplish this. Gradually filling the lungs with air whilst retracting the shoulders and extending the chest, or taking a deep inspiration whilst extending the arms above the head and expiring whilst placing them parallel with the body, are two simple exercises which do all that is necessary, and can be taken without interfering with the most busy life or causing fatigue. A habit should be made of thus ventilating the unused portions of the lungs, and it should be done at times when the purest air can be secured. The most practical germicide that we as yet know of for the bacillus tuberculosis is fresh air, or, more correctly speaking, it furnishes the least favorable habitat for its development. A better oxygenation of the blood is, moreover, secured by such exercises, the circulation is stimulated, and, indirectly, the digestion and assimilation improved.

As regards the hygiene of phthisis, when the disease is once established, it is based upon the same principles as that for its prevention. Sufficient nourishing food, and sufficient fresh air, these are the *sine qua non*. The prime object in every case of phthisis should be to secure a good digestion and assimilation. Everything that is done should be done with this object in view. Good, nourishing, and easily digested food should be taken in abundance, and every care taken that the stomach be not deranged by indiscretions in eating and drinking, or by overloading. As soon as the body begins to nourish, the lung trouble will improve. As an aid to digestion outdoor exercise is very important. Without it the system cannot be made to use up a large quantity of food. Inasmuch as warm climates offer greater inducements to keep invalids out-of-doors, and make bedroom ventilation a little more agreeable, they are highly commendable to consumptives; but they are by no means essential to their well-being. A cold climate will do just as well if the patient has the courage to endure the discomforts entailed by it. It is much better that a comsumptive have home comforts in the worst climate in the world, than that he be compelled to undergo the tortures of boarding-house or fourth-class hotel life at a health resort. In all warm climates the houses are built for warm weather use, and no provision is made for the stray blizzard that occasionally comes along. Though the temperature may be very

equable from day to day, there is always a marked variation between day and night. In consequence of the rapid radiation of heat the houses become cool and damp during the night, against which there is likewise no provision, except in first-class modern hotels. In many places suitable food is difficult to obtain even at the most extravagant prices. All in all, the average person who has consumption had better remain at home, unless his home is in a large city, and then he should go into the neighboring country, where he can secure home comforts and plenty of suitable food. Let him dress warm, take outdoor exercise whenever he can, eat plenty of light, nourishing food, take ample rest and sleep, and he will get along much better in his native heath than he would with small means in the most model consumption climate. It is important that the entire body be warmly clad in cold weather. Either silk or woollen clothing ought to be worn next to the skin. The circulation should be kept equable throughout the whole body, hence the extremities ought never to be let get cold. When the feet get cold, the lungs become congested. Rubbing the body with a coarse towel has a good effect in equalizing the circulation. The ancients recognized this fact, and laid stress on it. "Balneum alienum est," says Celsus. Sponge baths, if carefully taken, will do good. They should, however, be taken in a warm room, and followed by a rest. Sea-voyages used to be highly recommended in the early days of medicine, and theoretically, at least, ought to be beneficial in the first stages of the disease. The ocean offers a pure atmosphere, and frequently the salt air stimulates appetite and improves digestion. In the advanced stages of the disease they are, however, impracticable, and should never be attempted.

Gypsy life, or travelling through the country by easy stages and camping-out, is most beneficial to consumptives, even in advanced stages. The ancients had their patients carried from place to place in chairs. In the territories most remarkable cures are brought about by this mode of living. Persons unable to walk are hauled in wagons on improvised beds, and it is astonishing what a revivifying effect constant exposure in the open air has. But, as said in the beginning of this paper, when consumption is once established it is rarely cured, and though much can be done to ameliorate the condition of the consumptive, the most important duty of the medical profession, at the present day, is to lend its aid in bringing about such a change in public and private hygiene as to give the disease less chance for development.

Civilization is the keystone on which the barrier to the progress of phthisis must be built; but it must be a high order of civilization, a civilization in which charity for our fellow-man is the guiding star—which teaches not only how to live, but how to let others live—which banishes want from the earth, gives everybody sufficient breathing space, and removes the foot of monopoly from the neck of the working-man and the goad from his side; which will remove morbid ideas about dress, society, customs, and education, and banish all vice and excess from the world. So long as the objects of man's existence are to live at ease, gratify every desire, and tower head and shoulders above everybody else in importance; so long as one-half of the human race must be without the necessaries of life in order that the other half may revel in excess; so long as crowded tenement-houses must tower in the sky in order to let palaces spread out on the surface; so long as soulless corporations can drive men to do more than a whole day's work for half a day's pay, and under circumstances and surroundings which are in conflict with every rule of health; so long as the rich lead and the poor follow in health-ruining fashions and customs; so long as children have their minds made morbid and their bodies ill-developed by school-cramming processes; so long, indeed, will consumption continue to be epidemic, no matter what progress scientific medicine may make.

REDUCTION OF THYROID DISLOCATION OF THE THIGH-BONE.

BY A. ADY, M.D.,
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I was called, May 10, 1887, to see a mulatto woman, 25 years old. She had been under the treatment of an itinerate female practitioner for two months; was said to have rheumatism. Liniments had been used freely, along with internal medication.

I found her unable to walk from soreness about the left hip and thigh. She could not use crutches, because the lame leg was two inches longer than the other. A glance at the deformity showed that the head of the thigh-bone was in the thyroid foramen. I could get no history of traumatism from either the woman or her husband, both declaring that they knew of no cause for the dislocation. But I learned from a neighbor that the woman had been thrown over a

fence by her husband about the time the lameness commenced.

After making my diagnosis I repaired to my office to study the dislocation on the skeleton. Here I found on laying it on its back on the floor, and placing the head of the femur in the thyroid foramen, that by bringing the dislocated bone across its fellow, that the trochanter minor came in contact with the spine of the ischium, making a fulcrum, by which the head of the bone could be lifted out of its false cavity and on a level with the acetabulum. My patient was quite thin, and I concluded that the dislocation could be reduced by a similar manœuvre, as I knew, from a vaginal examination, that the spine of the ischium was quite prominent.

The next day, with the help of my partner, Dr. G. O. Morgridge (now professor of surgical pathology and of ophthalmology in the College of Physicians and Surgeons, Keokuk, Iowa), she was etherized, and placed upon a thin mattress on the floor. She was laid on the edge of it, so that the sound limb would hang over and be more out of the way. Seating myself beside her on a low stool, I grasped the knee and leg, keeping the latter fully extended, while Dr. Morgridge steadied the pelvis. The luxated thigh was now brought across the sound one, until the trochanter major became quite prominent, and it was judged that the head of the bone was lifted high enough to pass over the rim of the acetabulum. The femur was then pushed directly towards the articular cavity with a slight rotary motion, when it went in easily, but not with the snap usual in a recent dislocation, as the cup had been partly filled by granulations. It stayed there, and the patient made a good recovery after having an abscess of the thigh.

TYPHOID FEVER.

BY J. A. LONG, M.D.,
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In what I have to say on the subject of typhoid fever and its treatment I will confine myself to the facts as I have observed them in a long practice in this section—lower East Tennessee.

Typhoid fever first showed itself in the winter and spring of 1843–4, in an endemic form, under the various names of winter, *slow*, and *nervous* fever.

The onset of the disease is uniformly slow and tedious, the patient not being able to tell on what particular day he was taken with the disease, moping around for a week or ten days, complaining of little or no pain, but of weakness only, while he is not disposed to do any mental or physical labor; but is listless and dull, with sensations of cold or chilliness, or even a well-marked chill, recurring at irregular times during the first stage of the disease.

At this stage of the fever the tongue becomes coated with a white fur; it is smooth and glossy with its tip and edges red, and when the patient is told to protrude it, he invariably puts it out tremulously and may not withdraw it until told to do so.

The tongue undergoes many changes during the progress of the disease. If the fever runs a tedious course, the coat turns brown and becomes dry, and the upper layer of the mucous membrane peels off, leaving a fiery-red surface. Soon after this the coat begins to form anew; and this change may take place several times before the disease terminates in convalescence or death. During these changes the tongue presents a speckled appearance, and in grave cases it becomes black and deep furred, while dark sordes form on the teeth.

The pulse is generally small and accelerated, ranging from 90 to 120, according to the grade or stage of the disease, with a double or reacting beat.

Headache comes on during the second week and lasts for about ten days, with or without medicine, and then passes off, not being much influenced by remedial measures. This symptom is pretty uniform in typhoid fever. About the same time, or during the second week, the fever increases, the pulse becomes more accelerated, and an eruption of rose spots makes its appearance on the front parts of the chest and abdomen, and in a few cases it may be seen on other portions of the body. The rash makes its appearance at a certain stage of the disease, passing off at a later date. I have observed it at the commencement of the second week, and also as late as the end of the third week. In my experience it has been formed in ninety per cent. of all the well-marked cases of typhoid fever.

Delirium, which comes on in all medium and grave cases, is of a muttering character. It is unlike the delirium of most acute diseases in that the patient, in the midst of his mutterings, can be aroused when spoken to, and may answer one or more questions intelligently enough, and then lapse into the same state of derangement. In a very small percentage of the cases the delirium is wild, furious, and of a belligerent character; the

patient is hard to control and tries to force his way out of bed, resisting the kindly efforts of his attendants, even striking at those who oppose him; but such cases are the exception, and not the rule in typhoid fever.

The temperature in typhoid fever ranges from 100° to 105° in grave cases, and the gravity of the case is pretty accurately indicated by the range of temperature.

The abdominal symptoms in typhoid fever are among the most prominent of the disease. Diarrhœa usually commences early in the disease, and is more or less troublesome throughout its entire course. The discharges are generally green or greenish in color, and as a rule without smell. Their passage along the bowels is attended with a gurgling noise. If this latter symptom be not present, it is easily induced by pressure made upon the abdomen, and especially if made over the right iliac region. The bowels are more or less tympanitic in most of the cases, and this symptom is generally in proportion to the gravity of the case. Bleeding from the bowels is a common symptom in typhoid fever, and especially apt to occur when the too free use of purgative medicines, at any stage of the disease, has caused irritation of the ulcers of the small intestines, which are known to exist in every well-marked case of typhoid fever.

Typhoid fever as it shows itself in this locality is both infectious and contagious. This is certainly the case among persons who are at the age in which typhoid fever oftenest occurs (between ten and thirty years), and especially if they are exposed as nurses, or are about the sick room much of the time. Many instances could be cited in which young persons have gone a distance of miles to wait on a sick friend, and after returning home have been taken down in a short time with the fever, making new centers for the spread of the disease.

My experience is that typhoid fever seldom attacks children under ten years of age. I have met with but one case of typhoid fever where the patient was under ten, and that one was a child in its ninth year. From many circumstances that have fallen under my observations in practice, I believe that one attack of typhoid fever exempts the person from future attacks of the disease, at least as much so as in other eruptive contagious diseases. I am aware this is denied; but I think the denial is mainly founded upon faulty diagnosis. I have practiced medicine in the same locality for forty-four years consecutively, and I have never met with typhoid fever twice in the same individual. I have attended in the same family at different times, where the older children, in their teens and over twenty had the disease, and where the younger children, under ten years of age, were exposed as much as those who had taken it, but escaped entirely. Five years later I was called to the same family, and the younger children, who had grown up into their teens, were sick with typhoid fever, while some of the older children, still living at home, who were equally exposed to the same infectious causes, and also to the contagion of their sick brothers and sisters, entirely escaped the ravages of the disease.

Diagnosis.—The diagnosis of typhoid fever is plain and easy when its history, symptoms and course are carefully and patiently studied. The grouping of symptoms is remarkable in this disease: its slow, tedious and insidious attacks; the peculiar, dull expression of the face; the characteristic tongue and pulse, as described in this paper; the prominent abdominal symptoms, diarrhœa, bleeding from the bowels, epistaxis, rose-spots, etc. There is no disease that is likely to be mistaken for typhoid fever, but the typhoid type of many diseases; "and unless we distinguish between typhoid fever proper and the typhoid type in many diseases, there is an end to all philosophical diagnosis."

Prognosis.—Nothwithstanding, this fever is a terror wherever it makes its appearance, I believe there is no disease which has so strong a tendency as typhoid fever to terminate favorably if it is not aggravated by maltreatment. Whenever the time arrives in medical progress when typhoid fever is not regarded as belonging to the class of eruptive fevers, infectious and contagious, which cannot be cut short by the use of strong drugs, then its fatality will be lessened.

Treatment.—This should be strictly *eclectic* to be successful. Symptoms must be met as they arise in the case, with the mildest possible means at our command. The temperature is to be watched closely, and it should be kept in safe bounds, because it is *fever that kills*. This can be controlled by tepid sponging, with a little vineger in the water—not by ordering it attended to once, twice or a half dozen times a day—but by teaching the nurse to *keep the fever down* by going over the whole surface repeatedly, until it is completely under control.

In the stage of incubation the patient is liable to aggravate his case greatly by staying out of bed too long. One of the first things to be done is to request the patient to lie down and keep in bed, and as quiet as possible. If the weather is warm the linen should be changed at least every other day,

and in some cases this should be done daily. In cold weather the change should be made at least every third day by good, handy, sensible nurses. If the feet are inclined to be cold, they should be bathed in a mustard bath as warm as the patient can well bear it. This may be repeated every day, if necessary.

As soon as there are signs of ulceration in the glands of the small intestine—and this is one of the earliest symptoms—I put my patient upon an emulsion of turpentine, and do not wait, as most authors advise, until the tongue is dry and dark. This is giving the ulcers of the bowels all the headway possible. The emulsion I make of a solution of gum Arabic and turpentine, so that one teaspoonful contains one drop of the turpentine. This is given every hour, except when the patient is asleep. When he awakes, I begin again, counting the hours from that time. Other symptoms, such as diarrhœa, are met by the mildest means. In mild cases, Dover's powder answers a good purpose. In cases of bleeding from the bowels, acetate of lead and opium meet the indication.

Diet.—This is an important part of the management of typhoid fever. In the first stages of the disease I usually allow only toast-water, rice-water, toast, coffee, etc. Later, the diet can be cautiously increased. Fomentations to the bowels, when there is tympany, is an excellent manner of allaying irritation. I do not prescribe some *great thing*, but simply conduct the patient safely through the different stages of the fever.

—The Young Men's Institute of New York, a branch of the Young Men's Christian Association, has established a medical benefit club for the members of the Institute. Any member in fair physical health may join the club upon payment of the initiation fee of fifty cents, and the dues are only fifty cents for three months. Payment of these small sums of money entitles a member of the club to free medical service from a physician chosen and paid by the governors of the Institute, and to a discount of 25 per cent. on prescriptions compounded by any druggist designated by the physician.

The object of this club is not to make money, as is the case with many somewhat similar associations in England, but to assist the members of the Institute, which is actually a charitable concern, although every effort is made to keep this fact in the background, and to encourage a feeling of manly independence among its beneficiaries.

Society Reports.

PHILADELPHIA COUNTY MEDICAL SOCIETY.

Stated Meeting, January 11, 1888.

The President, J. Solis-Cohen, M.D., in the chair.

Dr. Lawrence F. Flick read a paper on

The Hygiene of Phthisis.[1]

Dr. T. J. Mays, in opening the discussion, said: I have listened with much interest to this remarkable paper, which expresses a view which I did not think existed to any extent in this city. The author attributes the existence of pulmonary phthisis to the bacillus tuberculosis. I do not think that such a view is borne out by the facts. If it were true that phthisis is propagated by contagion, those who are the most exposed to the disease should be those who would be most liable to contract it. The facts prove that this is not the case. Probably the best evidence of this is found in the history of Brompton Hospital, of London, when the report was made a few years ago. This hospital had been in existence thirty-six years. It has a capacity of nearly four hundred beds. The history includes all those who were connected with the hospital as physicians, nurses, etc., during this period. Not one case of the disease could be traced to the hospital as the source of contagion.

Dr. Brehmer gives some remarkable results in his book on the *Etiology of Pulmonary Tuberculosis*. He states that in the town of Görbersdorf, where his hospital is located, that the mortality rate of the native inhabitants from phthisis twenty years ago, at which time the hospital was established, was fifty per cent. greater than at present, notwithstanding that during that time there have been present about twelve thousand consumptive patients, who have freely mingled with the citizens. It also often happens that at health resorts for consumptives the physician himself is the subject of the disease, and yet, under such circumstances, frequently improves in spite of the presence of the tubercle bacilli. The author advocates a strict quarantine against the bacilli. Precisely such a quarantine was carried out in Naples for sixty years, up to forty years ago, but the results were entirely negative. In another statement the author is, I think, not borne out by facts. He states that females are more liable to the disease than are

[1] See page 135.

males. I have recently gone over an enormous amount of statistics, collected in this country and abroad, and they show that females are much less liable to the disease than males. The report of my statistics will be found in the *Medical News* of January 7, 1888. The fact that the disease is less frequent among females may be accounted for by the fact that they have a more extended apical motion than the male, and we know that consumption never occurs in any one who has a well-developed apical expansion. On the whole, one cannot help but be pleased with the paper; but while I admire it, I cannot agree with all the statements which it contains.

Dr. J. Daland said: I think it has been well ascertained that an hereditary predisposition does play an important influence in the causation of phthisis. With reference to the climatic treatment of phthisis, I do not think that this can be dismissed with the few words which the author has given to it. There seems to me to be no doubt that in the early stage of the disease, particularly in young men, that a change to a colder climate is of benefit. The disinfection of the sputa is a point on which sufficient importance is not usually placed. It is a matter of the greatest moment, and should be employed in every case of phthisis.

Dr. S. Solis-Cohen said: I believe that it was Mr. Spencer who thanked a certain philosopher for benefitting him by expressing opposite opinions in a forcible and eloquent manner. I can make my acknowledgments to the reader of the paper in similar language. I admire the suggestiveness and the vigor of his paper, but I find it almost impossible to agree with any of the theories advanced. As to the practice advocated, physicians of experience are all of nearly one mind; nor has Dr. Flick permitted himself to be led astray in this matter by his theories. The question of the omnipotence of the bacillus tuberculosis is one which deserves to be ventilated on every occasion. I have already to-night quoted the remarks of Dr. B. W. Richardson in another connection; but as I consider him the master-mind in medicine of the nineteenth century, I need offer no apology for again quoting him. He says, "What have we done, to be visited in the heavens above, in the earth beneath, and in the waters under the earth, with the *pestis bacillorum* which is now regnant?" Everything is bacillus. Dr. Richardson believes that it will not be long before the bacillus of pregnancy will be discovered. I think that Dr. Flick has himself given the strongest argument against the bacillophobic views he advances. The chain of events graphically described from several starting-points invariably concludes in—malnutrition and consumption. Malnutrition is the fundamental, the bacillus is the accidental. It may be that the bacillus does, when inoculated under certain circumstances, cause tuberculosis; there is some doubtful evidence bearing on this point which cannot be dismissed in a discussion of this kind. Even admitting that inoculating with the bacillus will cause consumption, there is no evidence that the inhalation of the bacillus will cause the disease. The inhalation of sputa and the inhalation of the bacillus are two different matters. The pus-cell and the coccus pyogenes are not at all synonymous. There may be in the mixture which goes to make up the sputum an element similar to those bodies which we know as the leucomaines and ptomaines, which, in a person predisposed and in low condition, may be capable of exciting the disease by interference with nutrition or otherwise. The evidence on all these points is very far from being clear. But granting, for argument's sake, that the microbe is one of the existing causes, we must still recognize, as the reader of the paper has pointed out, that the bacillus is everywhere present; and no matter how powerful are the means brought against it, they are incapable of destroying it or of dislodging it when it is once in the lungs. Even if we could destroy every bacillus in the lungs, at the very next breath the enemy is once more within the stronghold. Therefore the only rational thing to do to prevent consumption, whether the bacillus be a cause of the disease or not, is to build up the nutrition of the individual by the measures mentioned to-night and by others. We must utterly discard the misleading, and therefore destructive, idea that by bringing germicidal agents against the bacillus tuberculosis we can benefit our patients in the least. Treat the patient, and the bacillus will take care of itself.

The question of the marriage of those who inherit the tuberculous diathesis—and that there is such a diathesis universal experience goes to prove—is a very important matter, and, notwithstanding the views advanced, I think that every one of us should warn against the marriage of those whom we have reason to suppose would transmit such a woful inheritance. The question of baths in consumption is an important one. There are two methods of failure of function in consumptive patients which we must recog-

nize. The one is a failure of assimilation, and the other, no less important, is a failure of excretion. The skin is an important excretory organ, and it cannot be kept in the best functional condition without bathing. While we may not plunge a patient into a cold bath, we must see that he keeps the skin of the entire body cleanly, and as active as circumstances permit. Baths at a moderate temperature, when possible, or if not, daily sponging of the entire body should be insisted upon. This will often relieve pathological sweating. It is also a question of the greatest importance in how far we shall check sweating by drugs, whether, to reduce the skin to a dry and hot condition, is not far more dangerous than the very moderate perspiration for which atropia and other drugs are frequently given. This question must, of course, be decided in every case upon its own merits, with due attention to all the circumstances. Still I feel that it is often better to depend upon our general measures for the relief of this and other special symptoms than to resort at once to symptomatic medication.

Dr. M. Price said: I would ask Dr. Flick with reference to his experience with inflammatory conditions as a cause of phthisis. I do not believe in hereditary consumption. I believe that ninety per cent. of the cases of consumption come from some inflammatory condition as the starting-point. I am a firm and positive believer in the inflammatory origin of consumption. In nineteen years of practice I have not seen more than three or four cases in which I could not discover an inflammatory cause. I believe that without this inflammatory starting-point, consumption is impossible.

Dr. Flick said: I felt considerable hesitation in presenting this paper, as I knew that the opinions expressed were in conflict with those of many on the subject. I have strong convictions on the subject, however, as I have myself been the unfortunate victim of the disease. I have given the matter a great deal of thought, and have observed the effect of many remedies and of hygienic conditions. I do not know that those who have discussed the paper got my exact ideas on the subject. I hold that consumption is entirely dependent for its initial starting-point on malnutrition. I hold that without malnutrition and malassimilation such a thing as consumption cannot take place. I think that when one is run down he is then a fit subject for the bacillus tuberculosis, and unless he is run down and his digestive apparatus is out of order he will never fall a victim to phthisis, no matter of what his parents or his grandparents died.

The objection based upon the fact that nurses in hospitals do not contract the disease from their patients, is not well grounded. The nurses and others connected with a hospital are generally well nourished, as they get everything that is necessary to keep up their condition. When they get below par they fall victims to the disease. I believe that no consumptive patient derives benefit from climate in itself. The benefit comes from the change of life and from the out-of-door life. If the patient lives an out-of-door life and takes nourishing food he may recover. If he goes to any climate and stays in the house he will die.

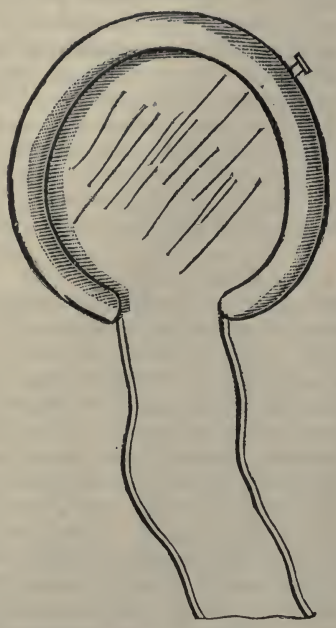
With regard to the relative frequency of the disease in males and in females, I would state that my statistics are drawn from the census reports of the United States. I have no doubt that inflammatory conditions of the lungs have some bearing on the production of the disease, inasmuch as a person who has had pneumonia is left in a depressed condition. I think, however, that a mistake in diagnosis is often made. I believe that a case is often considered to be one of pneumonia when really it is a case of phthisis. It is said that pneumonia has run into phthisis when in reality it was a case of phthisis from the beginning. I have brought this subject forward with the hope of exciting discussion. This is a matter which is too much neglected. There is no disease that causes as many deaths as does consumption, yet we have become so accustomed to it that we do not give it the attention which it deserves.

Dr. Howard A. Kelly read a paper on

Rubber Cushions for Surgical Purposes.

It is now almost a year since I put in the hands of Mr. Levick, manufacturer of rubber goods, several designs of cushions for surgical purposes. These cushions resemble those commonly used by students at lectures, in having an inflatable rim, but differ in being left open on one side, being C-shaped or rectangular, with one side out. They have a bottom of rubber sheeting extended into an apron some inches in length for the purpose of drainage. I have had constructed three separate forms, a large C-shaped cushion measuring about twenty inches in diameter, the opening of the C being about eight inches across, and the apron twenty inches in length. The rim measures about two inches in diameter when inflated. This pad I constantly use for abdominal sections; it is also of great

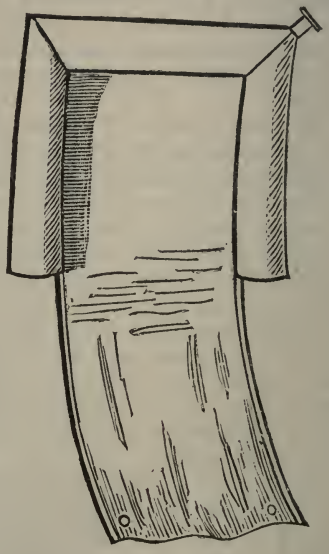
service in obstetrical cases requiring operative manipulation. It permits the free use of water for douching purposes; drains all blood and water from the field, enabling the operator to return the patient at once to bed,



without the necessity of removing clothing or changing linen. It has each month saved me more than its cost in the wash at my private hospital. A similar pad of the same pattern, measuring but ten inches in diameter, is in use on the examining table in my office, in all cases in which it is necessary to douch out the uterus or vagina.

The third pattern, which is in constant use for minor gynæcological work, is the perineal cushion. It is rectangular in shape, opening on one side, having a rubber bottom and long apron similar to the preceding. When in use the patient's clothes are elevated, and the thighs held flexed on the abdomen by my "Beinhalter." The buttocks are drawn down over the edge of the inflated rim, and the apron which hangs down from the edge of the table carries off all blood and the water used throughout the operation. There is no one device in all my gynæcological work which has given me so much comfort as these simple cushions. I use gallons of water with the utmost freedom, and without ever being obliged to think once where it is going. In perineal work, instead of using sponges, I use constant irrigation, which prevents clotting of blood, soiling of instruments, and replaces at no expense, and with greater comfort and satisfaction, the sponges formerly used. The work thus accomplished is neater and cleaner, and the results are better.

I also present now for the first time a design for a rubber bed-pan. It is oblong in shape with an inflatable rim and a rubber bottom. It differs, however, from any previous device, in the fact that one end communicates with a large, funnel shaped reservoir, terminating in a large nozzle through which the fluids are finally discharged. The whole peculiarity of the device depends upon the funnel and its outlet; the funnel is very broad at the top, being the full width of the cushion, about seven inches in depth to the tube, terminating in the discharge pipe of the same length, which is perforated at its under side by a buttonhole for attachment, when in use, to the rim of the cushion. When the cushion is in use the rim is inflated, the discharge pipe is buttoned to the rim, and



the patient is placed upon the cushion. Vaginal or rectal injections are now to be given. The fluid, as it is discharged from vagina or rectum, accumulates on the floor of the cushion, the amount this will hold depending entirely upon the depth of the inflated rim and the size of the cushion and reservoir. When it is desired to empty it, the rim is caught in the hand at the upper end, and carried with the funnel hanging downward; all fluids at once gravitate into this, but do not escape, owing to the attachment of the discharge pipe to the rim. It is then carried to the closet and the discharge pipe unbuttoned, when the fluid rushes out; it is further cleaned by allowing the water to run freely through it in the same manner.

The advantages gained by this device are very great. The softness of the rubber is a great advantage over the hard bed-pan, the capacity of the cushion is much greater, and may be made to vary with the size of the reservoir alone. It can thus be used for purposes for which the bed pan is entirely inapplicable. The facilities for cleansing are perfect, eliminating the chief objection to which the rubber cushions hitherto in use are open. The ease of transportation is also an available feature, as when collapsed it can be rolled up and packed away in small space. It can also be used for continuous irrigation, by leaving the discharge pipe, which can be made of any length, hanging over the side of the bed, discharging on a piece of rubber sheeting which conducts the fluid into a bucket.

Dr. J. Price said: The only matter about which any question exists, the only thing in controversy, is whether Dr. H. A. Kelly has any claim whatever as the inventor or originator of the irrigation pad. Such claim he has not only set up here but elsewhere, without, I assert, a shadow of authority in fact. Introducing the instrument here he has made it legitimate matter for discussion, not only as to the merits of the instrument, but the genuineness of its authorship. About five years ago I conceived the importance of an irrigation pad or cushion, and from a design of my own my friend, Dr. John Madison Taylor, made a drawing. The instrument, as drawn, was ordered through Kolbe. Dr. H. A. Kelly saw it not only at the instrument store, but also at my office. He there examined it, and we discussed its merits. I here present a bill from the New York Rubber Company for making this operating cushion, dated January 7, 1885.

Dr. Kelly said: I am sorry that anything so unpleasant should have come before the Society, and I should not have brought up the matter had not the remarks in reference to it been made so publicly after the last meeting that I have been forced to defend myself. I can only repeat that I have no recollection that Dr. Price ever spoke to me on this subject.

—A thoroughly equipped children's ward has been added to the Presbyterian Hospital, West Philadelphia, through the liberality of one well-known lady, and the new ward was opened on January 31. It is hoped to interest others in its support, the funds of the hospital being required for the maintenance of the sixty free beds in the general hospital. Five thousand dollars is required to endow a bed in perpetuity.

NEW YORK ACADEMY OF MEDICINE.

Stated Meeting, January 19, 1888.

The President, A. Jacobi, M.D., in the chair.

A Method of Prophylaxis in Diphtheria.

Dr. August Caille read a paper upon the Prophylaxis of Diphtheria, in which he said that every physician of experience had probably noticed that in certain families one or more members regularly become sick with diphtheria in the spring or fall of the year. It had occurred to him that the persons thus afflicted might harbor the microbes or essentials to the development of the disease from one attack to the other in the nasal and oral cavities. To test the correctness of this opinion of auto-infection, he chose eight children, who had prior to 1885 suffered from two or more attacks of diphtheria, and instructed their parents to carry out the following directions: First, all carious teeth were to be filled or extracted, and to be examined by a dentist from time to time; second, the mouth was to be rinsed three times a day after meals with one of three solutions, namely: a three per cent. solution of chlorate of potassium in water; a five per cent. solution of liquor sodæ chlorinatæ in water; or a saturated solution of borax in water. Some of the liquid was to be drawn up the nose. These instructions were carried out faithfully, and during two years, from 1885 to 1887, none of the persons experimented upon contracted diphtheria, although some of them had light attacks of pharyngitis and amygdalitis. In the family of three, the mother and nurse had diphtheria, but the children escaped. This form of prophylaxis, he said, had received scarcely any mention in medical literature. Inasmuch as we were ignorant of the true nature of diphtheria, we could not claim ability to make a diagnosis, especially in the early stage, between this and other affections of the throat and mouth; hence the importance in all doubtful cases, and indeed of every case of disease of these cavities, of protective measures, consisting of cleansing and disinfection. Parents should examine the mouths of their children before they go to school in the morning, and when sore throat is prevalent the children should be kept at home, and the above measures carried out.

The President mentioned as two possibilities in connection with diphtheritic infec-

tion, that the poison might rest in the enlarged lymphatic bodies or diseased mucous membrane in one who had suffered from an attack, and thus auto-infection take place. The slightest scratch might be the seat of erysipelatous inflammation; this he thought might also be true respecting diphtheria, particularly when the abrasion lay in the mucous membrane of the oral or nasal cavities. Those suffering from any acute affection of the mucous lining of those cavities are more liable to take diphtheria when exposed to it than others were. Another point of importance is the fact that children suffering from diphtheria often had relapses before complete convalesence, and this he considered due frequently to reinfection from the poison resting in the furniture of the room. Hence the importance of change of rooms, if not of dwellings, and of thorough airing, if not disinfection.

The discussion was participated in by Dr. Seibert, who emphasized the necessity for keeping the stomach in good condition if we would have children's mouths clean; by Dr. L. E. Holt, who had the impression that enlarged tonsils predisposed to diphtheria and made the attack worse, in which opinion the President agreed; by Dr. Winters, who, when diphtheria existed in a family, gave the well children full doses of tincture of chloride of iron, quinine in tonic doses, and calomel in mild purgative doses; and by Dr. Fruitknight and Dr. Harrison.

Dr. T. R. Pooley then read a paper on

The Induction of Premature Labor in Amaurosis and Amblyopia in Albuminuria from Pregnancy.

Among the indications for abortion in the albuminuria of pregnancy, disturbance of vision had not received the attention which its importance should demand. It had long been known that pregnant women were liable to disturbance of vision, but its importance had not been realized until written upon by Dr. Loring, who was first to suggest the induction of premature labor to save vision. It was true that in the case related by Dr. Loring it could not be shown by other symptoms that the kidneys were affected, but the value of his suggestions held good in this class of cases. The disturbance of vision connected with the albuminuria of pregnancy did not usually become prominent before the last months, and often grew worse for a time after pregnancy ceased; yet the lesion in the eye might begin at an early period after conception, as was evident in some cases in which an ophthalmoscopic examination was made. The disturbance of vision might come on suddenly or gradually; it might be transitory or permanent; it might be slight or extend to complete loss of vision. The author related one case in his own practice, and several others in the practice of different physicians, in some of which spontaneous abortion took place with immediate marked improvement in vision. In others pregnancy was allowed to go on to full term. In others premature labor was induced, with improvement in the eye symptoms. He thought nature had given us a valuable lesson when in some cases she brought on spontaneous abortion, after which the ocular difficulty improved. He believed an ophthalmoscopic examination should be made regularly in all cases of pregnancy, just as we now examine the urine for albumin.

Dr. Loring agreed with the author regarding the necessity for ophthalmoscopic examinations early in pregnancy. He spoke also of optic difficulties connected with other disturbances of the uterus than those related to pregnancy, but which in one case had nothing to do with nephritis.

Dr. Murray had frequently made examinations of the eye with the ophthalmoscope during pregnancy, and, according to English observers, as quoted by Dr. Loring, the lesions referred to by the author of the paper as occurring in the albuminuria of pregnancy were present in more or less degree in a large percentage of the cases. Yet few women who had albuminuria had eclampsia, and few of these again had serious optic difficulties. Therefore such examinations, if generally practiced, would only give the physician and patient unnecessary anxiety.

After some further discussion the academy adjourned.

—Diphtheria and typhoid fever are prevailing to an alarming extent in the neighborhood of Ottawa, Canada. Every town and village has been visited by either one or both of the epidemics, and the death-rate during December, 1887, from these causes was unprecedented. Twenty per cent. of the deaths in Montreal in one week recently were from diphtheria. In Ottawa, typhoid fever appears to be the most prevalent. The hospitals are full to overflowing, and can take in no more patients. A commission has been appointed to hold an investigation. The water supplied to the city is being drawn from the vicinity of a creek into which all the refuse of a tannery is emptied, and which an analysis shows is terribly polluted.

Reports of Clinics.

ROOSEVELT HOSPITAL, NEW YORK.

SURGICAL CLINIC—PROF. SANDS.

Ellstädter's Operation.

On January 7, 1888, Professor Sands presented a patient at his clinic who came under his care under peculiar circumstances. Not long since he had received a letter purporting to come from a country physician, who asked Dr. Sands whether the latter thought a cure possible in a case of fistula of the chest following by a pleurisy, which had then existed several years. The correspondent stated that if Dr. Sands considered the disease curable, the patient would be sent to him. The writer at the same time begged for information generally regarding the affection, and asked to be referred to some work treating of the subject. In reply, Dr. Sands informed the supposed doctor that the affection was curable, and that by means of Ellstädter's operation, and referred him to the *Archiv für Chirurgie* for further information. Some time thereafter a man called at Dr. Sands' office and introduced himself as his correspondent. It was subsequently learned that he was not a physician at all, but was himself the patient. He is thirty years of age, and single, and was admitted to the hospital on January 5, 1888. He says that he never was a strong man. Five years ago he had some brain trouble and an attack of pleurisy, with effusion. The fluid was aspirated four or five times, and, according to the patient's account, a gallon removed. In December of the same year (1883), an incision was made in the sixth intercostal space, and a drainage-tube introduced; but the fistula never healed. The breathing on the left side at present is found to be good; on the right, poor. His chest, upon the right side, is sunken and hollowed out from side to side. Dr. Sands thought that aspirations in cases of purulent exudations were of no use, in fact injurious; and that such exudations should be looked upon and treated as abscesses, that is, by incision. He objects to two openings being made, one, in his opinion, being sufficient; and does not believe in excising ribs, unless it really becomes necessary. "In the present instance the case is different; this patient has already two openings, and the chest, being flattened, the lung could not expand, because the lung is bound down by adhesions and would not resume its volume, even after a cure had been effected." On being tested, the cavity of the sinus was found to hold a gill, and to extend upwards for about four inches; laterally and inferiorly to a much less distance. An incision having been made in the side of the chest, the skin flags turned back, and the periosteum loosened from the ribs, a considerable portion of ribs was excised, and the soft tissue, consisting of thickened pleura, was then cut out by a curved incision. The wound was then probed. Dr. Sands was surprised to find that the sinus ran upwards for eight inches; and, greatly disappointed in his expectations, he decided not to excise any more ribs unnecessarily, as he now doubted of the cure he had promised this patient, but consoled himself with the knowledge that he would at least obtain good drainage. Two drainage tubes were then introduced, two being used so as not to exert too much pressure in the first place, and in the second, in order that the cavity might be washed out more readily, if necessary. The wound was then sutured and dressed in the usual way.

Stricture of the Urethra.

The second case presented to the class by Dr. Sands was one of stricture of the urethra. The patient was 42 years of age, had had gonorrhœa three or four times before he reached his twenty-eighth year, but no attack since then. From the last attack he did not fully recover, having had a "running" ever since. The stream of urine which he is able to pass has become smaller and smaller, and he has now to pass his water every two hours at night. A prior examination revealed the fact that he had many strictures. The attempts to pass the larger and then the smaller sized sounds being unsuccessful, a filiform bougie was introduced. The Maisonneuve urethrotome thus guided, first a small-sized and then a large-sized knife was used to cut through the strictures. A few of these were present in the penile portion, and several in the course of the canal, among which was a very resisting one at about the junction of the membranous with the spongy portion of the urethra. The introduction of a No. 20 catheter and the drawing off of the urine was the final step. Prof. Sands is in the habit of leaving these cases severely alone for seven or eight days before beginning dilatation.

—The reports concerning the condition of the Crown Prince of Germany continue to be encouraging.

Hospital Notes.

Bellevue Hospital, New York.

(Service of Prof. F. S. Dennis.)

For the following reports we are indebted to Dr. Thomas McCann, House-Surgeon.

Contusion of the Eye.

P. H., 25 years old, and a laborer by occupation, was admitted to Bellevue Hospital on August 28, 1887. While at work on the afternoon of August 27, a piece of steel or stone struck the patient's left eye. The following condition of things was found on his admission twenty-four hours later: The eye was greatly inflamed, the cornea sloughing, and eye-ball protruding. Leeches were applied and cold compresses used. On August 30, hot applications were substituted for the cold, and a canthoplasty advised and executed. The eye immediately bulged through between the lids and became constricted. Cold and hot applications were alternately applied, and atropine drops, which had been used every three hours since the patient's admittance, were continued. A panophthalmitis resulted. The eye was left to discharge. On September 5, the eye was discharging freely; there was no pain in the right eye. On September 10 the eye was still discharging, but the inflammation was subsiding. By September 20 the discharge had ceased. The patient was discharged cured on October 3.

Dislocation of Knee.

T. L., 64 years old, was admitted on September 12, 1887, having injured himself by falling down a cellar-way. Upon his admittance there was found a backward dislocation of the knee, which, being reduced, an existing fracture of the internal condyle of the femur was also discovered. A peculiar pinching of the skin at the side of the knee-joint was taken notice of, appearing as though the integument had been caught between the head of the tibia and the inner condyle; but this, upon close questioning, was found to be due to an old cicatrix, which gave rise to this appearance. Continuation of cold applications was advised. On September 19, the limb had improved considerably, but still presented a great amount of redness about the inner condyle. On manipulation, attention was called to the great outward mobility of the leg, and a closer examination revealed a rupture of the internal lateral ligament. On September 25, the limb had been on a double inclined plane for some time; a lead and opium lotion was applied; the limb was gradually improving. On October 6, a posterior splint was applied, and the patient allowed to get up. He was dismissed on October 13.

Sarcoma of Neck.

L. M., 62 years old, married, a native of the United States, was admitted to the hospital August 15, 1887, with a large growth on the left side of the neck. The patient said that a similiar but smaller growth had been removed eight weeks previously. On September 22, the growth being cut down upon, was seen to involve the sternal end of the clavicle, and as much as possible of it was removed. The bifurcation of the innominate artery was plainly seen and felt in the course of the operation. On September 24, the wound was dressed, and was looking well. Five days later the wound had broken open, and was filled with granulations. On October 1, the surface of granulations was found to be larger and spherical in shape, evidently malignant. By October 12, the new growth had become fully as large as before, and evidences of pressure upon the trachea began to appear. On October 19, the growth was much larger than any of the previous ones, and showed a large surface of granulations. It was not deemed advisable to remove the tumor, and the patient was discharged on October 30.

Neuroma.

S. St. J., 53 years old, a native of the United States, was admitted on October 3, 1887. The patient said that he had had an amputation performed at the shoulder-joint, twenty-nine years ago, for an injury to the arm; and further that this region has been more or less painful for the last fifteen years. On manipulation a small deep-seated and very sensitive tumor was felt. The tumor was cut down upon and excised on October 4, and was found to be a neuroma of one of the cords of the brachial plexus. The wound was drained and dressed in the usual way. On October 7, the wound was dressed and the tube removed; the wound looked well. On October 12, the wound was dressed; it looked slightly angry. The patient was discharged cured on October 19.

Necrosis of Humerus and Tibia.

T. B., twenty-eight years old, a native of the U. S., was admitted on October 10, 1887. His trouble began last February, when he was first taken with rheumatism, and subsequently noticed a swelling of his left leg. This had been lanced, giving exit to a "dark matter." Some two months thereafter he

noticed a swelling of the right arm. The swelling of the right arm was cut down upon, on October 11, and a necrosis of the humerus was discovered. The bone was gouged out, scraped, and the wound packed with iodoform gauze, and dressed. The tibia was next cut down upon, and an extensive necrosis of that bone found. This was chiselled, and a piece about three-quarters of an inch wide by two inches long cut out, the centre of which was necrosed. This cavity was also scraped out, and the wound plugged as above. On October 14, the patient was doing nicely. By October 21, the wound in the arm had almost filled up. On October 22, the wound of the leg was found to be doing very well. Sponge-grafts were introduced into the leg on November 1.

Supra-Pubic Lithotomy.

P. R., aged eight, was admitted September 23, 1887, with a history of calculus of the bladder. He was sounded, and the stone being detected, supra pubic lithotomy was performed. The bladder having been injected, an incision was then made in the median line, in the usual way. A catheter being introduced, the peritoneum was then pushed back, the areolar tissue separated, and an incision next made down upon the catheter into the bladder. This incision into the bladder being enlarged, the stone, the size of a hazelnut, was then easily removed. A drainage-tube was next introduced into the bladder, and the wound allowed to heal by granulation. The abdominal wall was stitched up and around the drainage-tube, and the wound dressed antiseptically. On September 27, the boy's condition was fair; he showed slight evidences of peritonitis for the first three days. On October 6, the wound having separated, was filling with granulations, having a surface two inches square. The boy's condition was otherwise good. By October 13, the granulation surface was gradually decreasing. On October 21, the patient passed water by his urethra. On October 29, the patient developed an abscess on the left side of the neck, which was due to a decayed tooth. On October 31, the abscess was incised. The temperature had gone up to 104.8° F. November 2, the wound of the neck had healed. A hair-lip pin was then introduced into the vesical fistula, and the edges of the granulating wound brought together. November 5, the pin was found of no benefit, as the patient still passed urine from the abdominal wound. By November 10, the wound had entirely healed, and the patient was walking about.

Periscope.

Therapeutics of Diphtheria.

In a paper in the *Medical Record*, Dec. 24, 1887, upon the therapeutics of diphtheria, with especial reference to the oil of turpentine, Dr. Simon Baruch, who has had great experience with this disease as attending physician to the New York Juvenile Asylum and the Manhattan Hospital, says that disinfection of the throat is best accomplished by the frequent internal administration of tonic, astringent and antiparasitic remedies; not by the brush, probang, or atomizer. Neither water nor food should be permitted for ten minutes after the medicine has been swallowed, thus allowing it to bathe the diseased surfaces. When the patient is tractable and willing to aid the attendant, he advises the hourly application of a fifteen per cent. solution of tripsin. In one case a ten per cent. papayotin solution proved equal to tripsin, but much more expensive. In *nasal* diphtheria the tripsin solution is invariably prescribed, to be applied hourly with the medicine dropper or soft brush, because this can be accomplished without damaging the mucous membrane, even in an intractable child. It softens and pulpifies the false membrane, and facilitates its removal by injections of salt water, or 1 to 10,000 bichloride, which in this dangerous form he orders applied at frequent intervals. When the air-passages are involved, he also resorts to local treatment by inhalation of the vapor from boiling lime-water impregnated with oil of turpentine—one ounce of the latter to one quart of the former, used continuously. When properly applied, he says these inhalations have aided him in saving several of his patients from tracheotomy. Great care should be taken not to deprive the patient of an ample supply of pure air while the inhaling apparatus is in operation. It is a common practice, which he admits formerly practicing himself, to surround the patient by all possible safeguards against the escape of the medicated vapor. A tent is usually constructed around the couch, excluding to a great extent the air, and compelling the patient to inhale the vapor continuously in its fullest concentration. This is an irrational practice. A patient suffering from laryngeal stenosis requires a plentiful supply of oxygen. Hence it is of vital importance to enforce at least as free access of fresh air to the chamber in laryngeal as in the other forms of diphtheria. It is only necessary to direct the vapor by means of a tube to the immediate vicinity of the

patient's mouth. This application requires constant and unremitting care. In this, as as in every other detail in the treatment of diphtheria, vigilance is the price of success; the physician must himself devote time to instructing the nurse again and again. The nurse should be warned against admitting cold air currents to reach the patient. As the latter is usually more or less somnolent in laryngeal diphtheria, it is not difficult to execute the necessary steps.

As to the general management of the patient and his surroundings, it is universally admitted that cleanliness of body, quietude of mind, and gentleness in nursing are among the chief elements of successful treatment. One point, however, he thinks deserves mention. In severe cases, especially if protracted, a change of rooms produces a marked effect. A fresh room, which has been thoroughly ventilated for twenty-four hours; a fresh bed, supplied with clean, well-aired linen, mattresses and blankets, and new surroundings, will effect a marvellous change in some protracted cases of diphtheria.

The administration of easily digested broth, milk, and stimulants must be left to the indications of each case. Care should be taken, however, to limit the quantity of food in proportion to the digestive powers of the patient. There exists in this disease, as in typhoid fever, a tendency to overfeeding.

As to internal medication he says his practice is to give every case of diphtheria, not presenting diarrhœal symptoms, a full dose of calomel, from four to eight grains, according to age. This is followed in six hours, if necessary, by a saline laxative in the mild tonsillar cases, while in the more severe types the action of the calomel is aided by ʒj to ʒss of oil of turpentine. The latter usually produces several pultaceous stools. The gastro-intestinal tract is now prepared for the reception of food and the necessary medication; the temperature is usually reduced, and the patient's comfort enhanced. Hitherto these were the chief objects of the calomel treatment. We have now, he thinks, another reason for its value, in the fact that calomel in purgative doses has been successfully used to abort other infectious diseases, as has been demonstrated by Ebstein and others.

Tincture of the chloride of iron is another remedy which he prescribes in all cases of diphtheria, but he gives it in doses from eight to twenty-five drops every hour, only sufficient glycerine and water being added to somewhat soften its astringent taste; the more concentrated the better the local effect. It is administered two hours after the calomel, and continued hourly or bi-hourly night and day. He lays stress only upon one point, unimportant as it may seem; *food or stimulants may precede the iron, but should never follow it immediately.* Then a local effect is obtained, which is readily recognized in the shrivelling of the deposit and the reduction of the circumjacent lividity. Bichloride of mercury is prescribed in all severe cases, especially when the uvula, nose, or larynx are involved. He administers oil of turpentine in doses of one drachm to half an ounce to children from six to fourteen years of age, once a day, oftener in cases demanding it. It may be given pure, followed by milk, or mixed with milk, or in emulsion. Vomiting occurs sometimes after the first dose, but the drug is usually retained afterwards. On two occasions his hospital nurse, alarmed by the rapid spread of the deposit, administered an ounce to children of twelve and fourteen years of age, with good effect. In about fifty per cent. of the cases it produces a laxative effect; it always stimulates the secretions of kidneys and skin; the odor is quickly detected in these as well as in the fæces.

He calls attention to the advantage of administering remedies in such form and rotation as to obtain their local antiseptic effect in connection with their general effect, and states that the entire number of cases treated by the method above indicated was thirty-nine—thirty being in hospital, nine in private practice. Mild and doubtful cases were rigidly excluded from this record. Among these thirty-nine cases there were two deaths, both in hospital practice; one occurred in sixty hours, and the other in fifteen days. In the first fatal case swallowing was so difficult that medication was not properly executed; in the second case the deposit disappeared so rapidly in three days that turpentine and bichloride were discontinued. Gastric irritability appeared several days later, when iron also was suspended. The patient died from neuritis.

Contributions to the Surgery of the Lungs.

Zielewicz reports the case of a boy, fifteen years old, who had been affected with a pneumonia, secondary to an attack of measles. Three months later, in examining the patient, he established the existence of an encysted pleural effusion, containing pus. He resected the sixth and seventh ribs to give vent to the pus. After having washed out the cavity he examined it by reflected light, and discovered on the surface of the lung a small orifice of the size of a pea, from which ichorous

pus escaped. With the aid of a long bistoury he enlarged this opening and then introduced his little finger into it. The cavity was thus found to be large enough to hold a walnut, and occupying the lower lobe of the left lung. The opening was tamponed with strips of iodoformed gauze, the ends of which were free and were brought out of the thoracic cavity. The cavity of the empyema was also tamponed in the same way. Then a dressing of chloride of sodium and sublimate gauze, with a layer of cotton, was applied. Cure resulted in eight weeks.

In another case, the patient was a man thirty years old, who had empyema, for which the thorax had been opened. Three weeks later, the opening which had been made contracted to such a degree that drainage no longer occurred, and fever resulted from the retained pus. Zielewicz then resected the seventh rib, washed out the pleural cavity and explored the surface of the lung with his finger. He happened upon a depression which, examined under sufficient light, had all the appearances of the residue of an abscess of the lung on the way to recovery, and of having been the point of departure for the empyema. Six weeks later, the patient had completely recovered. The author adds that he has not devoted himself to deciding whether the abscess was complicated with gangrene or not, as all the facts of the case place it in the category of those in which recovery from empyema occurred through surgical intervention. —*Gazette Médicale*, December 10, 1887.

Cocaine in the Treatment of Diseases of the Skin.

S. Lustgarten reports to the *Wiener med. Wochenschrift* that in Prof. Kaposi's clinic for skin diseases, painting with a two per cent. solution of cocaine has been found effective in diminishing the itching of acute and subacute eczemas. In eczemas of the genitalia and of the buttock, a two to five per cent. ointment of cocaine in lanolin proved itself particularly useful. In pruritus ani, suppositories, each containing three-fourths grain of oleate of cocaine, are employed in addition. It has also been used for the following purposes: in a one per cent. ointment for painful abrasions of any kind; in two per cent. watery solution to paint upon granulations which are to be touched with nitrate of silver; and also as an injection into the urethra in painful erections, chordee, etc., in the course of gonorrhœa. It has also been used with a two per cent. solution of carbolic acid, in the form of hypodermic injections, in order to produce local anæsthesia for minor operations, such as extirpation of epitheliomas, circumcision, and the like. In the same way it suffices for making painless hypodermic injections of calomel, for which purpose the needle of the instrument should be allowed to remain in the tissue while the barrel is removed to be filled with the calomel mixture. Arsenic injections can be made in the same way. If these substances were added directly to the cocaine solution, decomposition would occur. Daily use of cocaine in calomel injections the author regards as inadvisable, on account of the danger of inducing toxic effects. In some few cases the author observed palpitation of the heart, and general indisposition, tremor of all the extremities, and once even an epileptiform attack, from the hypodermic use of three-fourths of a grain of cocaine.

Scrofulous Neck and its Surgical Treatment.

Dr. William F. Gibb, in a paper published in the *Glasgow Medical Journal*, January, 1888, after discussing scrofulous neck and the remedies proposed for its relief, states his opinions in the following propositions:

1. In scrofulous disease of cervical glands we have a tubercular process of a mild type, seldom leading to generalized infection, but perhaps occasionally doing so; frequently concerned in predisposing to, or even directly occasioning, phthisis pulmonalis; and in the majority of cases detericrating the general health.

2. Tubercular disease of the cervical glands is too often allowed to go on to a disastrous extent, without any active steps being taken to arrest its course, largely from a prevalent indifferent and helpless feeling on the part of the medical profession.

3. Slight cases, being of course offered every possible advantage in the matter of constitutional treatment, should be carefully watched; and if, after the lapse of months, or it may be a year or two, we find the disease spreading, it is wise to extirpate the affected glands while they are yet movable. In such cases the operation will be easy, and little or no deformity need result.

4. To quote Teale, whose directions are full and clear, surgical interference is demanded whenever a sinus resulting from a degenerating gland exists; whenever pus can be detected in connection with a gland; and whenever there are enlarged glands accessible to surgery in a patient in whom a caseous or suppurating gland has already been discovered.

The author appends to his paper four cases illustrative of the disease and its treatment.

The Usefulness of the Trichloride of Iodine as an Antiseptic.

C. Langenbuch, of Berlin, communicates to the *Berliner klin. Wochenschrift*, No. 40, 1887, a paper upon the usefulness of trichloride of iodine as a disinfectant and antiseptic. He finds that it does the work, in abdominal surgery, of a four per cent. solution of carbolic acid, or of a five-hundredth of one per cent. to one-tenth of one per cent. solution of bichloride. Riegel has declared that there is no fear of poisoning from its use in surgical practice; but, in spite of this assertion, Langenbuch states that he always employs it cautiously, especially at the beginning. The following are his conclusions with regard to the antiseptic power of the trichloride, which we take from the *Allgemeine med. Central-Zeitung*, Dec. 7, 1887:

1. In watery solution, the trichloride is an active disinfectant, being capable of killing vigorous spores of bacilli, even when it is in great dilution (1–1000). Solutions in oil and alcohol are inactive. Its spore-killing power surpasses by far that of carbolic acid, and, in this respect, among the ordinary disinfectants, stands next to the bichloride.

2. In its behavior toward bacilli free of spores, and toward cocci, it exhibits about the same activity, in a solution of one to one thousand, as a carbolic acid solution of three in one hundred. In greater dilution it in some experiments appeared to exceed carbolic acid in power.

3. The antiseptic properties of the trichloride are effectual in preventing the development of the micro-organisms of infectious wounds, if it is added to the nutritive gelatine in the proportion of one in two hundred.

The author concludes his paper by saying that he has used the trichloride in all kinds of major operations, and has obtained throughout successful results. In abdominal operations its value seemed particularly striking, as it was disinfectant without giving rise to any toxic symptoms. He has also used it internally in solutions of one part in 1200 to 1500 in dyspepsia with fermentation, and also as an injection in gonorrhœa.

Amylene Hydrate as a Hypnotic.

In the *Deutsche med. Wochenschrift*, January 5, 1888, George Avellis reports the result of experimentation with this new hypnotic in Riegel's clinic, at Giessen. The following propositions cover the results obtained in over three hundred trials with over forty patients: 1. Amylene hydrate can be depended upon as a hypnotic, if a sufficient dose is given. Control experiments have resulted in showing that it is weaker in this respect than chloral, but stronger than paraldehyde. 2. It also acts upon people who are accustomed to narcotics; yet for such patients a large dose (sixty grains) is required. 3. Sleep occurs for the most part quickly, without a preceding stage of excitement. The sleep is more or less sound in proportion to the size of the dose, but it is always possible to easily waken the patient. On being waked, the patients are completely clear in mind, answer questions correctly, and, if not further disturbed at once drop off to sleep again. 4. Sleep lasts, when small doses are given, two or three hours; when larger doses (thirty to thirty-six grains) are given, six to eight hours. 5. The awaking resembles entirely that of the natural sleep, and the patients feel strengthened. 6. The respiration is unaltered. 7. The change of pulse and blood pressure, apart from the slight slowing in the pulse rate which is to be observed even in normal sleep, does not occur after the administration of amylene hydrate, as is shown by sphygmographic tracings, which were taken by Prof. Riegel from different patients. 8. The bad taste and smell on awakening, which often after the use of paraldehyde annoys the patient and those about him, has never been observed from amylene hydrate. 9. Whether patients become accustomed to the drug, or not, can not yet be decided. In the author's experiments it was never necessary to increase the dose after it had been employed repeatedly for some time. In one patient, a hysterical woman, who had taken thirty-six grains of amylene hydrate, a condition of intoxication developed. The skin of her face was reddened, the pulse quickened; she was talkative, and stated that she was as though intoxicated. After the lapse of four hours, sleep occurred. Another patient took thirty-six grains at one o'clock in the morning, and on the next day felt as though he had been under the influence of a hypnotic. Probably the late hour at which the drug was taken was to blame in this case. The drug failed in three cases: one of these was a patient with delirium during erysipelas, one a patient with beginning insanity, and one a patient suffering from very violent neuralgia. In the irritative cough of phthisis, the cough was not increased, but rather diminished.

When the drug cannot be administered by the mouth, as in severe disease of the stomach, or ulcerous processes in the pharynx, it may be given with water and gum Arabic in the form of an enema.

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MASTURBATION IN WOMEN AND GIRLS.

The vice of masturbation is far from being limited to the male sex. The ancients designated female masturbators as *tribades*[1] (*tribein* to rub), and the Lesbian women from the time of Sappho, that ancient erotic woman, had the reputation of solitary sacrifice to Venus. There is evidence that phalli of wax or of wood were offered publicly for sale among the Romans, as now among the Chinese. That the odious practice has come down to modern times is also evident enough, and more than one romance of our day has called attention to the prevalence of the solitary vice (tribadism) among women.[2] Instances of each of the three following forms of masturbation frequently come under the notice of the physician: vaginal, clitoridian, urethral. Of these three forms, the clitoridian (simple titillation or friction of the clitoris by the hand), is the most common. Peculiar movements of the body, often calculated for this end, may accomplish the same titillation of the clitoris ending in voluptuous spasm. In one large tailoring establishment Pouillet found a number of girls who had become addicted to masturbation by the use of the sewing machine; they had learned the habit of sitting in such a posture that the motion of the feet on the treadle brought about a pleasurable friction of the clitoris by the thighs.[1] A confirmed female masturbator will practice the vice by rubbing the genitals against the arm of a chair, the corner of a piece of furniture, or even by divers contortions of the body. Vaginal and urethral masturbation has sometimes resulted in the lodgment of foreign bodies in those passages, and the intervention of the surgeon to remove the foreign body has been necessary. Dupuytren in one instance extracted a *tin-cup* from the vagina of a confirmed masturbator;[2] and, in another, a needle-case, introduced into the urethra, was successfully removed, after being present in this canal for a month.[3] The list of substances used for the purpose indicated is varied: from spools, needle-cases, bottles, glass cups, etc., in the vagina, to needles, ear-picks, pieces of wood, and hair-pins in the urethra. Confirmed victims of secret vice have been known even to provoke titillation of the uterus by hair-pins, pieces of reed, etc., as in an instance recorded in the *Journal de Médecine et de Chir.*, vol. xiv, p. 70.

With reference to the female masturbator observers have not failed to remark the obstinacy with which the vicious practice is often adhered to, despite every possible means of repression. Girls often begin this secret habit at a very young age, taught (though not always) by lewd nurses or playmates; and the frequency and persistency with which the pollutions are repeated, notwithstanding all opposing moral agency and all physical restraint, is appalling. Nearly all physicians at some time or other have had experience of such cases.

As for the causes of this vice, when we think of the altogether disproportionate share which sensual and sexual gratifications have

[1] Martial, 7–67; Phædrus, 4, 15.

[2] Thus *Mademoiselle de Maupin*, by Th. Gautier; *Mlle. Girard, ma femme*, by A. Belot; *La Fille aux yeux d'or*, by Balzac.

[1] *L'Onanisme chez la femme, 5ième* ed., Paris, 1888.

[2] Poulet: Foreign Bodies in Surgery, vol. ii, p. 195.

[3] *Ib.*, p. 218.

in the daily lives of multitudes, the intense pre-occupation of their minds with such matters and the interest taken therein—as is evidenced in the popularity and sale of certain recent French novels; moreover, when we consider the sure influence of heredity: "*Casta refert castæ genitricis filia mores; lascivæ nunquam filia casta fuit,*" we do not wonder at the numerous instances in which this unnaturally developed and predominant passion has overflowed the bounds of decency, morality and physiological sanity. Pouillet makes four principal orders of causes: (a) physical, (b) social, (c) intellectual and moral, (d) mixed. Among the physical causes, climate has a certain share: the salacity of the inhabitants of hot climates has been recognized from remote antiquity. Want of cleanliness is an important factor, provoking irritation of the genitalia by the acridity and irritation of retained secretions. The same irritation, provocative of frictions which end in habits of manustupration, may be caused by ascarides, vegetations at the entrance of the vagina, vaginitis simple or blennorrhagic, vulvitis—and especially that variety of vulvitis which is localized near the clitoris—pruritus of the vulva, certain affections of the skin and mucous membrane whether local or general, and certain inflammations of the uterus and ovaries. Highly seasoned foods and stimulating drinks may favor this vicious habit, and certain cases of inveterate onanism appear to have originated in cerebral disease. Numerous instances have been met with in which the abominable habit was a manifestation of an insane neurosis, idiocy, or dementia.

Among the social causes, an indolent, sedentary and luxurious life is doubtless influential. Every conceivable perversion of the sexual function prevails in the harems of the East. Lewd romances, lascivious pictures, examples which favor precocious or inordinate sexual development, may be reckoned among the intellectual or moral causes.[1]

In treating of the consequences of onanism, it may be remarked that these are essentially the same in both males and females. This vice entails just such functional incapacity and anæmia of the brain and spinal cord as do all the other sexual abuses. It is doubtless more the frequent repetition of the act, than anything else, which renders masturbation so deleterious. The miserable victim steadily loses will power, and suffers deterioration of the higher faculties; and eventually the unnatural passion becomes dominant. Doubtless women, in consequence of the greater delicacy of their nervous organization, are the greatest sufferers from the effects of this vice.

Making all due allowance for exaggeration, and for mistakes arising from simple concomitance, there is evidence that, besides neurasthenia, nearly all functional nervous diseases may have their origin in self-pollution; this remark is true of both sexes. Putzel reports a case of epilepsy in a female aged nineteen years, which was clearly traceable to an inveterate habit of masturbating, commencing at the age of nine years.[1] Tissot, in his treatise on onanism, alludes to the frequency of epilepsy in the female as a result of self-abuse, and the aggravation of the crisis by repetition of the pollution. More than one case of epilepsy has been benefitted, if not cured, by clitoridectomy.

There is an analogy between the venereal spasm and epilepsy which has given rise, among the older medical writers, to the application to the former of the term *epilepsia brevior*. There is some clinical evidence that that obscure and protean malady, hysteria, is often due to habits of masturbation (Jolly, Bridges, Tissot, Kiwisch, etc.); catalepsy, ecstasy and chorea have also been referred to this vice. Pouillet relates a case of a choreic patient under his care, who, after intervals of apparent reformation and health, would be again afflicted with chorea when she resorted to her old habits of masturbation.[2]

Whether or not the grosser encephalic and spinal lesions ever result directly from this vice, it may not be possible to assert posi-

[1] *Vide* Parvin, in *Medical and Surgical Reporter*, Dec. 24, 1887, p. 826.

[1] Functional Nervous Diseases, p. 53.

[2] Pouillet, *op. cit*, p. 152.

tively; at the same time there can be little doubt that a peculiar form of mental degradation and alienation, characterized by notable changes in the affective faculties and in the character, is frequently a consequence of self-abuse. The victims of the genesic vice are timid, sheepish, inordinately sensitive, irritable, capricious, impatient, selfish, unfeeling, incapable of lofty thoughts, noble actions or good sentiments. One marked characteristic of this class of patients is that they spend long periods without weariness in doing nothing, or in doing very trifling things. Maudsley says: "they are wrapped up in self; display a vanity and self-sufficiency quite unbecoming their age and position; exact the constant indulgence of others without the least thought of obligation or gratitude." "Perhaps," adds Maudsley, "it may be looked upon as a fitting retribution that the completed destruction of the moral sense should have its cause in the vicious abuse of that instinct in which it had its original root."[3]

SCARLET FEVER AND FOOT AND MOUTH DISEASE.

Among recent studies in regard to scarlet fever none is more interesting or more worthy of serious consideration than that of Dr. Stickler, of Orange, New Jersey, as described in a paper published in the New York *Medical Record*, December 10, 1887. In this paper, the author gives an admirable description of so-called foot and mouth disease as it manifests itself in man and in lower animals, especially of the equine and bovine species, and an interesting account of what he has learned, by reading and by personal observation and experiment, of its relation to scarlet fever. From this account it appears that accidental inoculation of human beings, with secretion from the lesions of animals suffering with foot and mouth disease, produces a disease so similar in its manifestation that it seems to be identical. A more remarkable result of his studies is the indication—we cannot say, and he does not say, proof—that a previous attack of scarlet fever protects against the development of the disease from the ingestion of milk from animals suffering with scarlatina. That this may be a fact appears to be proved by a careful study of the cases of epidemic sore throat occurring in Dover, England, in 1884, which were attributed to the use of milk from cows suffering with aphthous fever. We cannot go into the details which Dr. Stickler has obtained, with the co-operation of Dr. M. K. Robinson, medical officer of health of East Kent, England; but commend them to the attention of our readers.

Another deduction from Dr. Stickler's observations and experiments is the theory that designed inoculation with the virus of mild aphthous fever (foot and mouth disease) in cattle affords protection against the accidental production of scarlet fever by contagion. Impelled by his convictions in regard to the relation existing between these diseases—or, it may be, their identity—he has actually inoculated a considerable number of human beings with the virus of aphthous fever, and has afterwards deliberately exposed some of them to the risk of contracting scarlet fever, with every effort to make this risk as great as possible. The result has been fortunate for an experiment which most men would regard as extremely hazardous. None of the subjects of his experiments contracted scarlet fever! And no one can question the conclusion which he states, with every proper reserve, that such inoculation appears to have a prophylactic value analogous to that of Jennerian vaccination.

It is impossible as yet to state positively—and Dr. Stickler appreciates the fact fully—that inoculations with the virus of a mild aphthous fever will serve as a reasonably safe and sure protection against the accidental contraction of scarlet fever; but his studies and experiments are deserving of the most thoughtful consideration. Many of our readers may be in a position to throw light upon the relation of eruptive diseases among cattle to the appearance of scarlet fever among their patients, as we have already stated in the Reporter, Nov. 26, 1887; and we hope they will co-operate with him, and with investigators on the other side of the Atlantic, in eluci

[3] Maudsley, Pathology of the Mind, 3d ed., p. 453.

dating this important feature of the natural history of scarlet fever. As to preventive inoculations, we think they may for the present be left to those whose faith is clear in regard to their value; but we may indulge the hope that what Dr. Stickler suggests as to their worth as a prophylactic may not prove an *ignis fatuus*. If it be established as a fact, it will be of incalculable benefit to humanity.

EASTON PHYSICIANS FIFTY YEARS AGO.

We have received a copy of the *Easton Daily Express*, January 16, 1888, containing a communication from Dr. Traill Green, in which he defends the Easton physicians of about the year 1830 from a charge contained in the autobiography of the late Dr. Gross, that at the period in question the medical profession of that town was in a decidedly mediocre condition, without science, without learning, without progress, and apparently without ambition.

Dr. Green naturally objects to such a criticism of his townsmen, and warmly enters the lists to show that Dr. Gross's judgment was a mistaken one. In this we think he is entirely successful, and we share the general regret that one who in his life seemed to take such pains to avoid wounding the self-love of his fellow-workers should now be authority for a statement which certainly could not be expected to please them. The physician of fifty years ago cannot be judged fairly by the standard of the present day, and we have no doubt that the physicians living in Easton at that time were as conscientious, as intelligent and as skillful as any similarly situated medical men. The criticism of Dr. Gross must, therefore, be regarded as one of those lapses to which all men are liable, and from which no autobiography is free; and we trust that now, when the reputation of the Easton physicians has been so fully and so ably vindicated, the feeling naturally excited by the injustice done them will disappear, and the memory of Dr. Gross will not lose any of the honor which it deserves.

Book Reviews.

[Any book reviewed in these columns may be obtained, upon receipt of price, from the office of the Reporter.]

THE PRACTICE OF MEDICINE AND SURGERY APPLIED TO THE DISEASES AND ACCIDENTS INCIDENT TO WOMEN. By W. H. BYFORD, A. M., M. D., Professor of Gynæcology in Rush Medical College, etc., and HENRY T. BYFORD, M.D., Surgeon to the Woman's Hospital of Chicago, etc. Fourth Edition. Thoroughly revised, rewritten and enlarged by over one hundred pages, with three hundred and six illustrations. 8vo, pp. xxiv, 820. Philadelphia: P. Blakiston, Son & Co., 1888. Price, cloth, $5.00; leather, $6.00.

This large and handsome volume is one of the best recent productions in the field of gynæcological surgery. It is the work of experienced men, who have observed carefully and studied thoroughly the subject of which they treat. It is fully abreast of the present position of medical knowledge in regard to the diseases peculiar to women, and may be safely taken as a guide in their treatment. We note that the authors, without discussing theoretical questions in regard to it, are firmly convinced of the value of the so-called antiseptic method.

In looking through the book we observe an omission which might be filled by a careful study of the number of the Reporter for January 21, 1888. But omissions are not easy to find in it.

We cannot conclude our notice without a word of praise for the manner in which the publishers have co-operated with the author in making this book attractive and instructive. It contains a very large number of admirable illustrations, a hundred of which have been drawn and engraved especially for this edition; and the illustrations aid materially in making the text clear. We congratulate both the authors and the publishers on the appearance of their work, and recommend it heartily to our readers.

Pamphlet Notices.

A Contribution to the Study of Cysts of the Vagina. By George Woodruff Johnson, A.M., M.D., Washington, D. C., Lecturer upon Operative Gynæcology in the National Medical College, etc. From the *American Journal of Obstetrics and Diseases of Women and Children*, 1887, Nos. 11 and 12. 49 pp.

A Clinical Analysis of Sixty-Four Cases of Poisoning by Lead Chromate (Chrome Yellow) used as a Cake-dye. By David Denison Stewart, M.D., Chief of the Medical Clinic in Jefferson Medical College, etc. From the *Medical News*, December 31, 1887. 21 pp.

Report of a Case of Tuberculous Phthisis, Treated with the Pneumatic Cabinet. By William B. Wood, M.D. From the *New York Medical Journal*, November 12, 1887. 6 pp.

Report of a Case of Wladimiroff-Mikulicz Osteoplastic Resection of the Foot. By Wm. Barton Hopkins, M.D., Surgeon to the Episcopal Hospital, Philadelphia. From the *Medical News*, December 3, 1887. 7 pp. and a table of statistics.

ALUMNI SOCIETY OF THE MEDICAL DEPARTMENT OF THE UNIVERSITY OF PENNSYLVANIA. PROCEEDINGS OF THE ANNUAL MEETING HELD MAY 2, 1887, WITH AN ADDRESS BY JOHN T. CARPENTER, A.M., M.D., of Pottsville, Pa. Philadelphia: Collins Printing House, 1887. 23 pp.

THE UNIVERSAL HEALTH CODE. By EDWARD PLAYTER, M.D. Ottawa: Printed by Mason & Reynolds, 1887. 16 pp.

—Dr. Johnson's pamphlet contains an account of a case of multiple cysts of the vagina, upon which he operated in 1887, with a full history and description of this kind of tumors, and a very complete bibliography of the subject. The operation which he regards as the best for cysts of the vagina is that of Schröder, which consists in removing with scissors the part of the tumor-wall which protrudes into the vagina, and stitching the mucous membrane and the lining membrane of the cysts together around the line of the cut. In this way the cyst is turned into the vagina, and the remains of its lining membrane become converted into mucous membrane.

This pamphlet is illustrated with four good wood-cuts.

—Dr. Stewart's studies in connection with a large number of cases of poisoning attributed to the use of cakes artificially colored with chrome-yellow have led to his publication of a paper which is of very great medico-legal value. It is somewhat startling to note that in the sixty-four cases here reported there were eight deaths.

—Dr. Wood's paper contains an interesting account of a case of phthisis in which great improvement followed treatment by means of the pneumatic cabinet, and the result obtained seems to be justly attributed to this treatment. But there may be those who will question the author's sweeping statement that the results of this method "indicate the skill, little or much, that manipulated the instrument."

—Dr. Hopkins is the only surgeon in America, except Dr. Fenger, of Chicago, who has as yet performed this useful operation, which was aptly termed by Wladimiroff, who first practiced it, the operation for the artificial production of pes equinus. It has been well described by Dr. Fenger in the *Journal of American Medical Association*, January 29, 1887, and is well described by Dr. Hopkins in the paper before us, which contains an account of a case in which he obtained an excellent result. The paper is illustrated with two wood-cuts, and contains a table of twenty-two operations. This operation deserves to be better known and appreciated than it has yet been in English speaking countries, and Dr. Hopkins's paper is a valuable contribution to this end.

—This pamphlet is of the character usual to such reports. The address of Dr. Carpenter is interesting, and contains a recommendation that the Alumni of the University of Pennsylvania erect a memorial hall for public exercises. The report of the Executive Committee calls attention to the need of a fuller pecuniary support of the Society by the Alumni in general, and appeals for their aid and co-operation by joining the Society and paying the very moderate dues of one dollar a year.

—Dr. Playter's little tract contains a good deal of sensible advice in regard to a number of matters in hygiene and the treatment of emergencies and accidents. It is apparently addressed mainly to the young, but might be read with profit by persons of all ages.

LITERARY NOTES AND QUERIES.

[In this column the REPORTER will publish short items of literary interest and questions addressed to this Journal or its readers, and answers to them, in regard to any literary matters: books, authors, places and prices of publications, etc.]

—The *Illustrite Monatsschrift der Aertztlichen Polytechnik*, which recently united with the *Centralblatt für Orthopädische Chirurgie und Mechanik*, announces, in the number for January, 1888, that arrangements have been completed for the publication of a French edition of the united journals, which will be edited by Drs. Leblond, of Paris, and Pasquier, of Evreux.

—The *Journal of the N. E. Va. Medical Society* is an 8vo pamphlet of 22 pages, to be published monthly at Bethel Academy P. O., Virginia, by Thomas W. Smith; price, $1.00 a year. Vol. I, No. 1, is a sprightly number of 22 octavo pages, and contains matter of interest. It deserves the support of the members of the local society, and in later numbers will doubtless give evidence of more careful proof-reading.

—The *Journal of Dietetics* is a periodical published quarterly, at Cleveland, Ohio; price, 50 cents a year. During 1887 four numbers were issued, consisting in all of 88 pages. It has every appearance of being a trade journal, published in the interest of a malt-extract manufacturing company, and does not seem to deserve to be regarded as a medical journal in the ordinary acceptation of this term. The number for October, 1887, contains three articles, one of which seems to be original.

—*The Doctor* is the title of a 12 page quarto-size paper, published in New York, by Charles Avery Welles. It is issued twice a month; price, $2.00 a year. It aims to be chatty and interesting. The number before us is largely occupied by communications from Dr. J. B. Mattison, of Brooklyn, on the subject of narcotic *habitués*, in regard to which he seems to be somewhat of an alarmist. Under the head of "*Omnium Gatherum*," we find many interesting items, some of them decidedly more chatty than dignified. The general plan of the paper is good; but the number for December 1, 1887, does not impress us favorably.

—The *Medical Analectic*, with January 1, 1888, became a weekly journal instead of a monthly. The first number contained 16 pages; the second contained 12. It is made up wholly of abstracts taken from a variety of American and foreign medical journals, very much like the Periscope and Notes and Comments in the REPORTER. It is in many respects a very good journal; but we regret to observe that it begins the year by publishing advertisements in its reading pages, with head-lines exactly like those used for its scientific abstracts. This is a course which we think no properly conducted medical journal would pursue, and one against which we think subscribers to medical journals should strenuously protest.

—There is considerable excitement in Brooklyn about the increase of small-pox in Adams street, Willoughby avenue, Henry street and other localities. Since January 23, no fewer than twenty-three cases have been reported.

Correspondence.

Large Brain in a Woman.

Editor Med. and Surg. Reporter:

Sir:—On November 29, 1885, I made an examination of the body of Mary Steele, of Castleton, Vermont, who had died the day before from a prolonged debauch. The autopsy was made by order of the Board of Coroners. I was assisted by Drs. James Sanford and C. C. Nichols, of that town. The woman was of Scotch-Irish descent, unmarried, between 45 and 50 years of age, and nearly five feet ten inches in height. Her features were coarse, and she had a masculine appearance.

She was addicted to drink and brawls. Thanksgiving Day of 1885 was celebrated in such a manner, and in the brawl she was found dead. At the autopsy, the body bore many marks of violence, which even extended through the thoracic walls, and the lungs were found with patches of extravasated blood. The entire intestinal tract was congested. The brain was removed entire; the spinal cord being severed just below the medulla oblongata, and no portion of the dura mater being left attached. The veins on the surface of the brain were turgid with fluid blood; the structure seemed healthy. The organ seemed so large that we were induced to weigh it. Before doing this it was placed on a dry towel, and all the moisture was absorbed from the surface, and light pressure was made upon the organ to squeeze out any that did not properly belong there. The beam tipped quickly at fifty-five ounces avoirdupois. That there might be no doubt about the accuracy of the scales I had it verified with other scales.

Yours truly,

John M. Currier, M.D.

Newport, Vermont,
Jan. 12, 1888.

—In the Pure Food Convention at Washington, on January 20, resolutions were adopted urging the immediate enactment of laws to prevent the adulteration of foods, drinks and drugs. The convention refused to recommend special legislation in regard to lard and oleomargarine. A permanent National Pure Food Association was organized and officers were elected for the ensuing year. A vice-president from each State represented in the convention was also elected. The old Committee on Legislation was continued, but was strengthened by the addition of the President, three secretaries and the reasurer.

Notes and Comments.

Somnambulism Caused by Atropine.

In the *St. Louis Med. and Surg. Journal*, January, 1887, A. D. Williams tells the story of a man for whom he prescribed an atropine solution to be dropped in the eye for contusion of the cornea. The solution was of the usual strength (one grain to two fluid drachms?) and was ordered to be dropped in the eye five times a day. After two or three days of this treatment the patient arose one night towards morning, and in a somnambulistic condition, and clad only in his night shirt, left the house and walked eight or ten blocks away. It was during warm weather, and most of the houses had their windows open. Entering one of these he wandered about the house until awakened by the vigorous snoring of one of the sleepers. Making his way out of the house, he found himself in a strange neighborhood, and had some difficulty in finding his way home, being mistaken once for a ghost. Dr. Williams expresses the opinion that the atropine was the direct cause of the somnambulism, as the man had never before shown the slightest tendency to wander in his sleep. The frequency of application of the drops was diminished and no further ill-effects were noticed. Two other instances in which the drug produced temporary dementia in boys are also mentioned.

Salicylate of Soda for Dysmenorrhœa.

Dr. C. Mettenheimer, of Schwerin, reports in the *Memorabilien*, December 12, 1887, a case of dysmenorrhœa which was greatly benefitted by taking salicylate of soda during her menstrual period. The patient was a woman, thirty-eight years old, who had borne three children. She menstruated regularly, but the flow was scanty and accompanied with colic. She happened to have an attack of rheumatism at one of her periods, and Mettenheimer put her to bed, and gave her fifteen grains of salicylate of soda every hour. After she had taken four doses her rheumatic pains disappeared. At the same time her menstrual flow increased very much, but did not become free enough to excite any uneasiness. It also lasted a day longer than usual. It is not stated that the colic disappeared, although this seems to be implied in Dr. Mettenheimer's communication.

Glycerine Injection for Constipation.

The injection into the rectum of so small a quantity of glycerine as from a third to a half of a fluid drachm is said to produce a

stool in obstinate constipation in children or adults. In the *Memorabilien*, December 12, 1887, there is an abstract from the *Wiener med. Presse* in which the effects of the method and its mode of operation are well described. The results attributed to it there certainly invite to its trial.

New Blistering Liquid.

D. Boni (*Giorn farm. trent.*) recommends chloral camphor as superior to any of the ordinary vehicles for the active principle of cantharides. His preparation consists of

Camphor	20 parts.
Chloral hydrate	30 "
Cantharides	10 "

The pulverized camphor is mixed with the chloral hydrate and heated to 140° F. until fused, the bruised cantharides is then added, and the mixture digested at 140° to 158° F. one hour, with occasional stirring, then strained and preserved in a glass stoppered bottle. It is to be applied by a compress, or in the case of children or delicate women, simply pencilled over the surface. The circumstance that it is non-volatile gives it a great advantage over cantharidal collodion.—*Quarterly Therap. Review*, January 1, 1888.

Application for Gout and Rheumatism.

A mixture made up of

Ether	15 parts
Flexible collodion	15 parts
Salicylic acid	4 parts
Morphine	1 part

painted every hour on joints affected with gout or chronic rheumatism is said to afford great relief from pain.

Aspirating the Heart.

M. Budin thinks that puncturing the heart is practicable and not dangerous in the majority of cases, and that it is destined especially to remedy the dilatation of the right heart when there is no organic lesion. He recommends that the aspirating needle should be inserted in the third intercostal space on the right side, and close up to the edge of the sternum in aspirating the auricular cavity. When the ventricle is to be aspirated, the needle should enter the fourth intercostal space on the left side close to the left edge of the sternum. Puncture of the ventricle should be preferred, as the cardiac wall is much thicker and less prone to tear, and thus exposes less to hemorrhage into the pericardium. Cardio centesis acts as a depleter of the right heart, and might give great relief to a distended heart.

False Charge against a Physician.

The *Lancet*, January 14, 1888, states that false charges of an infamous character against medical men are too common. But one of a singularly audacious and mendacious nature has met with signal exposure and retribution in Ireland. An action was brought against Dr. Henry Davy, of Terenure, county Dublin, to recover damages ($5000) for alleged criminal connection with the plaintiff's wife. Three witnesses for the plaintiff in succession, his daughter-in-law, servant and daughter, said they had been offered money to swear falsely against the defendant, and had not a word of evidence to give against him. It seems that the mother had kept the family for years, and that the father and plaintiff was a ruffian and villain, who had always treated his wife and family in a shameful manner. The Recorder said that in all his experience he had never known a more atrocious or infamous case, or a more scandalous attempt to ruin a wife and to obtain money. He ordered the Crown Solicitor to prosecute the plaintiff for perjury.

Unique Method of Inducing Abortion.

Dr. A. Harris reports in the *Journal of N. E. Va. Medical Society*, Jan., 1888, that he was requested to see a case of alarming menorrhagia, at night, in an unmarried patient. The hemorrhage had begun some twelve hours before, and there had been suspension of the menstrual function for four months, which was ascribed to the patient having "taken cold." A digital examination revealed the presence of an ovum, which extended into the vagina and was removed and placed in a napkin. Although the mother a[illegible] of the patient were in her room

NEWS.

—Diphtheria is reported to be epidemic at Rittersville, a village of about two hundred families between Bethlehem and Allentown, Pennsylvania. About forty houses are infected, and a number of deaths have occurred.

—Dr. Manson, an English physician, has been summoned from Hong Kong to take medical charge of the young Emperor of China. This is said to be the first occasion on which a foreign doctor has ever attended a member of the imperial family.

—Dr. Addinell Hewson has been appointed by the Faculty of Jefferson Medical College to lecture to the classes in anatomy, at that institution, during the illness of Prof. William S. Forbes, M. D., who is confined to his home by an attack of erysipelas.

—A congress of physicians and veterinarians will be held in Paris from July 25–31, 1888. Any physician or veterinarian may become a member by registering and paying a fee of ten francs ($2.00). The subjects for discussion proposed by the committee on organization are:

1. The dangers incident to the use of meat or milk from tuberculous animals, and the way to escape them.

2. The human races, the species of animals, and their organic surroundings in respect to their proneness to tuberculosis.

3. The channels for the introduction and for the propagation in the economy of tuberculous virus, and measures of prophylaxis.

4. Early diagnosis of tuberculosis in man and in animals.

Other subjects may be discussed by members of the Congress, if they choose.

OBITUARY.

ROBERT A. GIVEN, M.D.

Dr. Robert A. Given, of Burn Brae, Clifton Heights, Delaware county, died Tuesday, January 10, in the 73d year of his age.

FREDERICK FLETCHER, M.D.

Dr. Frederick Fletcher, a resident of Bradford county, Penna., died suddenly in Wilkesbarre, Thursday, January 18, of paralysis, at the age of 70 years.

W. B. WILSON, M.D.

Dr. W. B. Wilson, a leading physician of Southern Illinois, died at Flora, January 17. His death was the result of blood-poisoning from malignant carbuncle. Dr. Wilson was for many years the chief surgeon of the Ohio and Mississippi Railway.

DR. ADOLPH LIPPE.

Dr. Adolph Lippe died on January 23, 1888, at his residence, No. 1204 Walnut street, after a brief illness of three days. Dr. Lippe caught a severe cold which resulted in pneumonia. He had been in feeble health for weeks, and from the first hour of his illness seemed to despair of his recovery. He was one of the best known homœopathic practitioners in Philadelphia. He was seventy-six years old.

HENRY INSLER, M.D.

Dr. Henry Insler, an old resident and well-known physician of Houghton county, Michigan, died January 18, 1888, at the home of his son in Calumet, at the age of 84 years.

Official List of Changes in the Stations and Duties of Officers serving in the Medical Department, U. S. Army, from Jan. 22, 1888, to Jan. 28, 1888:

Capt. H. G. Burton, Assistant Surgeon, granted leave of absence for one year on S. C. D., to take effect when able to travel. S. O. 19, A. G. O., January 24, 1888.

First-Lieutenant W. W. R. Fisher, Assistant Surgeon, granted leave of absence for one month, on surgeon's certificate of disability. S. O. 4, Dept. Cal., January 20, 1888.

Official List of Changes of Stations and Duties of Medical Officers of the U. S. Marine Hospital Service, for the week ended Jan. 28, 1888:

W. A. Wheeler, Passed Assistant Surgeon, granted leave of absence for thirty days. January 24, 1888.

J. H. White, Passed Assistant Surgeon, granted leave of absence for two days. January 26, 1888.

R. B. Watkins, Assistant Surgeon, granted leave of absence for thirty days. January 28, 1888. Resignation accepted, to take effect March 15, 1888. January 28, 1888.

G. T. Vaughan, Assistant Surgeon, appointed an Assistant Surgeon, January 25, 1888, *vice* A. D. Bevan, resigned; assigned to temporary duty at Marine Hospital, Boston, Mass. January 26, 1888.

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Lecture.

THE TREATMENT OF CARBUNCLE WITH CARBOLIZED SPRAY*.

BY PROFESSOR VERNEUIL,
PARIS.

Reported by Arthur C. Hugenschmidt, M.D.

For nearly forty years, during which time I have been practicing surgery, I have seen a great variety of methods employed in the treatment of carbuncle, and have observed that these methods tend to become less and less surgical or operative, but are no less efficacious on that account. At the beginning of my practice, like others, I treated this affection by very deep and long incisions. But I soon observed that this cruel practice was really not at all necessary, that it was even dangerous sometimes, and that in the majority of cases recovery was just as rapid without this proceeding. I then recommended, sometime ago at the Société de Chirurgie, to use the knife only in cases in which pain was violent, and when the disease showed a tendency to spread rapidly, leaving to themselves those which were not very painful or in which the affection was circumscribed.

As soon as Paquelin's thermo-cautery was introduced into practice, I substituted its use for that of knives, which often aggravates the disease by leading to septicæmia, hemorrhages, etc. I made deep and multiple openings, disposed in rings over the affected parts, plunging the cautery into the healthy parts all around. The dressing was an antiseptic carbolized one. The objection to this method was the time it required. When the lesion was extensive, as many as one hundred and fifty cauterizations were sometimes necessary, and they took at least twenty to thirty minutes to carry out—the patient being, of course, obliged to be put under the influence of chloroform.

In 1881 I had established the following rule: "Exceptional intervention only in grave and well-marked cases; but applied with energy." I varied my modus operandi, however, according to circumstances; and instead of using both the cautery knife and the cautery point, I used only the latter.

Such was my practice when, in 1883, I saw a very grave case of carbuncle situated at the posterior region of the neck in a man of strong constitution, but who was suffering from well-pronounced diabetes. The carbuncle was opened at its centre, and was progressing rapidly notwithstanding numerous incisions had been made with the cautery, and the wound had a very bad odor. On my first visit I decided that additional openings would be required, and that I would make them the next day. In the meanwhile I ordered the wound to be twice sprayed for one hour with a two per cent. solution of carbolic acid. On the next day the wound had no odor, and considerable diminution of the redness and swelling had taken place. I then resolved to try this method further.

Since then I have used the sprays exclusively against *all* carbuncles—small, medium or large; diabetic or not; painful or painless; still closed, or opened naturally, or by artificial means. This very simple mode of treatment I found superior to all others, in stopping the sufferings soon and in rapidly limiting the extension of the disease.

Amongst the cases I have treated, I may cite that of a young professor of the Paris Faculty of Medicine, who died lately of diabetes complicated with albuminuria. He

* A paper read before the Academie de Médecine, of Paris, January 17, 1888.

had a very large furuncle, or boil, on his left cheek, with diffuse and deep extension and considerable surrounding œdema. The prognosis was grave, not only on account of the seat of the trouble, but also on account of the presence of sugar, 3.5 per cent. Cardiac and pulmonary lesions rendered the administration of chloroform dangerous. I resorted to the carbolized spray. After the first application the œdema disappeared, the pain diminished and disappeared entirely in forty-eight hours; and after seven or eight days, in six of which the spray was used four times, the large furuncle was reduced to a medium-sized ecthyma pustule; and it was entirely healed by the seventeenth day.

Of course, this treatment will not prevent accidents which may occur when the carbuncle has given rise to an extensive sphacelus in extremely cachectic patients. But in the majority of cases, if taken early, we have in the spray an abortive treatment for carbuncle.

The manner of using the carbolized spray is known to every surgeon. A convenient apparatus is the atomizer, which is heated by alcohol, and which will work for twenty-five minutes. Such an one is sufficient for small or medium sized carbuncles, and for those which are already opened. For the large tumors, where the skin is not broken, it is better to use a more powerful apparatus, which gives off a more abundant vapor and has a more considerable force of penetration. The apparatus is placed from one to two feet from the skin, regulating the spray according to the sensation of the patient. I generally place nothing between the carbolized vapor and the wound, or I place there only a single thickness of transparent gauze. Up to this date I have used only the two per cent. solution of carbolic acid. I have not tried other antiseptic solutions, being contented with the results obtained with carbolic acid, which, in my experience, has never irritated the skin nor produced any symptoms of general disturbance. The number of applications of the spray is variable. Usually three or four sittings, of half an hour each, every day, are quite sufficient. Between the time of spraying, an antiseptic carbolic dressing should be applied to the lesion. The patient might find so much relief from the spraying, that the sittings could be made much more numerous—six or eight a day. The following precautions must be taken in this method: 1. Carefully protect the normal parts surrounding the carbuncle with compresses, rolled napkins, perforated cushions, or pieces of adhesive plaster perforated at the centre, according to the region which is occupied by the lesion; at the same time protecting the patient's linen and bed-clothes from becoming wet. 2. Place the patient in an easy position, so that he shall not be tired during the spraying. When the boil, or carbuncle, is at the back of the neck, or on the back, the patient should be seated on a chair, so that he can rest his folded arms on the back of the chair. When the disease is situated in the perineum, or near the anus, the lithotomy position is the best; and when it is in the lateral, lumbar or gluteal regions, the patient should lie on the side with the lower limbs flexed.

The treatment by the carbolized spray is not only very simple, but also adapted to all forms or phases of the disease, being the same from the first day to the last. When used at the beginning for a small carbuncle or boil, it has a good chance of aborting it entirely. Later, when the swelling is voluminous or has a tendency to increase, it will stop its progress. Later still, when mortification and perforations of the skin have begun, it limits the sphacelus, helps to the separation of the mortified tissues, disinfects the wound, keeps it clean, and by so doing reduces the temperature and the symptoms of general disturbance. Its advantages are increased by the fact that its application does not demand the use of chloroform, and that there is no need to touch the tumor or irritate it in any way. I have said, and I repeat, that the old method of incision with the lancet was far from being innocent, that these incisions produced in enfeebled patients severe hemorrhages, which were difficult to arrest, and which necessitated the use of painful hemostatics; and that they were capable of developing septicæmia, of propagating gangrene, and of favoring the absorption of putrid matter.

Many surgeons after having opened a carbuncle freely, scrape, excise or press the spongy mass to evacuate the pus and gangrenous materials. But these proceedings are at the same time dangerous and painful, and should be absolutely avoided; for the use of carbolized spray renders them unnecessary, by disinfecting the wound.

In order to appreciate the danger of using force on a carbuncle or furuncle, one must remember that the affection is of an infectious character, and that the tumor contains pathological microbes capable of extending on the surface, or of colonizing in the interior, by auto-inoculation, or by entering the general circulation.

This last fact is not as well known as it might be, although it is known that a car-

buncle, and even a boil, is capable of giving rise to fever, general symptoms, and even visceral manifestations—albuminous nephritis, and deep abscesses, for example.

In conclusion I would state the following views: 1. Furuncle and carbuncle are only different stages of one infectious disease, and are to be treated by the same therapeutical means. 2. The treatment consists in surgical interference or medical applications. The first was formerly thought to be indispensable, or at least was resorted to in the majority of cases. The second were thought to be efficacious only in mild cases, and were employed as secondary measures for relief. 3. To-day surgical intervention is becoming less and less necessary, and should be reserved for exceptional cases; on the other hand, antiseptic solutions of carbolic acid, of boric acid, etc., used in a peculiar way, and especially under the form of prolonged and repeated atomization, are remarkably efficacious, while they are at the same time very simple and free from danger. 4. Sprayings, with very few exceptions, lead to a rapid recovery from the manifestations of furuncle or of a small carbuncle, and they check the disease in graver cases. They very rapidly put an end to the pain, the fever and the general symptoms; they disinfect the purulent and gangrenous spots, and assist the cleaning of the lesion and the formation of granulation tissue. 5. Sprayings may be used in any region of the body for all forms, and in all the stages of the disease. They are never dangerous, and will alone bring on a cure in the majority of cases. They would also help greatly to the success of surgical interference, if such should be deemed necessary. 6. Finally, they prevent internal auto-inoculations and the phenomena of general infection.

—A fire occurred in the Hospital for the Ruptured and Crippled, in New York, on the evening of January 29. There were 163 crippled children in the building under treatment, and the youngest were in bed. The fire was discovered by two girls, both suffering from spinal disease, who notified a nurse. An alarm was given, and all the children were got out safely, the guests in the Vanderbilt Hotel opposite giving up their rooms for their accommodation. A 10-year-old boy, who is suffering from hip disease, tried to carry out a little deaf and dumb cripple, but the boy was too heavy. He then dragged him out to the hallway, where he met a policeman who carried both boys down. The fire was incendiary, the guilty person being one of the inmates, a little girl.

Communications.

SOME OPERATIONS ON HERNIA IN THE PHILADELPHIA HOSPITAL.

Reported by
EDWARD MARTIN, M.D.,
SURGICAL REGISTRAR.

Case I.—Michael Carter, glassblower, aged 36; right scrotal hernia, four years' duration, caused by a fall; had reached size of a baby's head when he began wearing a truss, one year ago. At times it would come down under the truss, but could be easily reduced.

Nov. 13, 1887, it came down early in the morning; the patient continued to work for some hours, then tried to reduce it, but unsuccessfully. He was received into the surgical ward the same afternoon. Ether was given and gentle efforts at reduction made, but in vain; pain and tenderness steadily increased; constipation obstinate, but no vomiting. Operation at midnight, by Dr. William S. Janney. Incision over tumor eight inches. Small intestine found in sac; no omentum (indirect inguinal, right side). Constriction at internal ring relieved and gut returned. Sac dissected up and sewed across with continued sutures of carbolized silk, the same thread then being passed through the conjoined tendon and out to the junction of the middle and inner thirds of Poupart's ligament, piercing it at that point; the latter structure being drawn as strongly as possible toward the middle line of the body. The sac was cut off below the line of sutures, crossing it; the wound was drained and closed with silver wire. The course of the case was typically aseptic. Temperature next day, 100°; thereafter normal till the eighth day, when, the bowels being opened, it immediately dropped again to normal. No suppuration. Cure apparently radical.

Case II.—Robert Taylor, white, aged 56, laborer; long-standing scrotal hernia, size of a large fist; much pain and constant dragging sensations. Operation for radical cure by Dr. Janney. Skin pinched up, and an opening three inches long made through integument by transfixion. The middle of incision was over the external ring. Careful dissection down to sac, which was found so extensive and closely adherent to surrounding cellular tissue that it could not be entirely separated. The freed portion was invaginated and stitched to the internal ring. The columns of the external ring were brought as near

together as possible. The wound was closed, drained, and dressed antiseptically. Suppuration the second day; temperature 102⅖°. The discharge of pus became shortly very profuse, burrowing into the scrotum, and requiring a counter-opening. This continued for four months, till the man had reached an extreme degree of emaciation; the discharge then gradually grew less, till in two months more the wound was entirely closed, and the man's body-weight greater than at the time of the operation. Four months after leaving bed the cure was still satisfactory. There was a hard cicatrix, occupying the position of the inguinal canal and extending into the scrotum. The man was able-bodied, and expressed himself as well satisfied with the result.

As observed by Dr. Janney, this case is of value as illustrating a cure in spite of a very violent inflammation and free suppuration following an operation in which much liberty had been taken with the peritoneum. The cure in this case was certainly rendered more permanent by the inflammation.

Case III.—Eliza Moran, white, aged 70, domestic; married, and has five children. There has been a lump coming and going in the left groin for four or five years. On each appearance there would be cramps and vomiting, lasting from a couple of hours to a day; the lump would then become somewhat smaller, and active symptoms would cease. There would be much wind passed from the bowel, and the patient would shortly be as well as ever.

One morning the hernia came down again; pain and cramps steadily increased till evening of same day, when she was admitted to the surgical ward. Palliative treatment was employed; the symptoms were progressive; stercoraceous vomiting beginning.

The operation was performed by noon of next day, by Dr. William G. Porter. The tumor was the size of a Bartlett pear and distinctly triangular in shape, occupying the left groin. An incision three inches long was made directly over the tumor and the sac opened, the constriction being at its neck. Three knuckles of intestine, giving the tumor its peculiar shape, and a mass of omentum the size of a man's palm, were found in the sac, all much congested. The bowel was readily returned after relieving the constriction; the omentum being adherent it was ligated and cut off, the stump being returned to the peritoneal cavity.

Following the operation the patient became delirious and tore off her dressings; there was shortly very free suppuration, but in spite of this she rapidly recovered.

Case IV.—Norah M., white, aged 40, domestic, very fat. There was a history of old ventral hernia, of four years standing. She was a multipara, and has had a laparotomy done upon her.

On April 17, sudden acute pain and vomiting, with constipation, occurred. She was admitted on April 20. There was very profuse fæcal vomiting; constant pain, with agonizing paroxysms; great prostration; abdomen tense and swollen; on palpitation a tumor, the size of a child's head, lying between the ensiform cartilage and umbilicus, slightly toward the left side, presenting the ordinary signs of a strangulated gut.

An operation was immediately performed by Dr. George McClellan. An incision six inches in length, from ensiform to umbilicus was made. Two apertures were found in the linea alba, above and apart from the umbilicus. Through the upper protruded about four feet of small and large intestines, covered by an old thickened and adherent sac. Through the lower and recent rent, protruded about eighteen inches of small intestine, in a state of livid congestion. Omentum slightly developed. The gut was reduced, and the walls of the abdomen, together with the peritoneum, fastened by gut sutures.

During the operation and until death, which occurred a few hours later, constant and copious stercoraceous vomiting persisted. To rid the stomach of fæcal matter, the stomach-pump was used, with apparently some benefit. The extremely exhausted condition of the patient prior to operation left her no reactive power, and in spite of a free use of diffusible stimulants, she steadily sank.

Dr. McClellan remarked that he fully believed in the use of the stomach-pump in such instances, being confident that large masses of fæcal matter and gases, even though there was but little absorption, exert a distinctively unfavorable effect upon the patient, far more marked than the disturbance incident to passage of the stomach-tube.

Case V.—William J., white, aged 35, a dyer, was admitted to the surgical ward on May 29, 1887, with history of long-standing inguinal hernia, for which a truss had been ordered but not regularly worn. Two days before admission, his truss being off, the hernia came down, and he was unable to reduce it. Pain and tenderness shortly set in, followed by some vomiting. On admission the vomit was not stercoraceous; the hernia, a right oblique inguinal, was extremely tender, about the size of a walnut, and could not be reduced. Operation was at once performed by Dr. John B. Deaver. An in-

cision was made directly over the tumor. This hernia proved to be an encysted hernia, or the "infantile hernia of Mr. Hey, of Leeds." This Dr. Deaver clearly demonstrated. Opening first the anterior layers of a patulous tunica vaginalis, the true hernial sac was exposed; this was in turn opened, and some adhesions between it and a knuckle of intestine broken up, when the bowel was readily restored to the abdominal cavity. The redundant hernial sac was cut away, and its neck stitched across with cat-gut interrupted sutures. The tunica vaginalis was separately stitched with cat-gut, and finally the wound was closed with silver wire. The operation was strictly aseptic in performance and sequel, the patient made an uninterrupted recovery, and is apparently radically cured of his hernia.

ECLAMPSIA AT END OF THIRD STAGE OF LABOR, AND COMPLICATED BY POST-PARTUM HEMORRHAGE.

BY R. B. McCALL, M.D.,
GEORGETOWN, OHIO.

Mrs. K., aged 33, a brewer's wife, and mother of three healthy living children, was confined for the fourth time, July 1, 1869. The previous labors had been natural and unaccompanied by a single untoward event. Gestation had been uninterrupted, and the present labor seemed to be as auspicious as any that preceded it. In due course the third stage supervened, the head descended and engaged in the vulvar opening. But suddenly, as it made its escape, my attention was arrested by a peculiar vibration or tremor of the body; and glancing at the face, I perceived that it was distorted; the woman was in the throes of eclampsia. The child was speedily delivered and the cord compressed. On pressing the hand gently through the vulva, the placenta was found occupying the vagina, and it was readily extracted. With the removal of the placenta came such a torrent of blood as I hope it will never be my fortune to witness again—so voluminous that it seemed death must be instantaneous and inevitable.

The muscles relaxed, the face became blanched, the eyes rolled back in their sockets, the jaw fell, and the woman appeared to be dead. The bed was saturated with blood, and a crimson stream flowed across the floor to the open fire-place, a distance of twelve feet. I was stunned for a moment, but only a moment, when I rallied all my resources; and although it seemed like an effort to restore the dead, to bring back life to a body from which the vital spark had passed forever, yet by that strange instinct which animates the heart and actuates the physician in the most appalling situations of his professional calling, I promptly sought and brought into requisition all the measures then known and used by the *accoucheur*.

Not only did I work with all my might and intelligence, but induced others to labor with a celerity and energy that was indeed commendable. The first thing done was not to pour, or attempt to pour, stimulants or restoratives down the throat, but to provoke efficient contraction of the inert uterus, if indeed there was any contractility left in it; and to this end a half-gallon of cold water drawn fresh from the bottom of a well in the porch, but a few feet away, was dashed from a considerable height on the exposed abdomen, and the operation was once repeated. The uterus became a firm, round, contracted mass. Hemorrhage was instantly stopped, but, alas! possibly too late for the welfare of the mother.

At this juncture attention was directed to measures of restoration. There was present that peculiar Hyppocratic physiognomy, or a very near approach to it, which says as plainly as articulate language can express it, that life is extinct: mouth open and jaw fallen, eyes turned up and filmy, surface pallid, bloodless, no pulse at either wrist, temple or elsewhere; no breathing that could be appreciated by the senses as such. Notwithstanding, by a very careful auscultation, the heart was found to pulsate very feebly, and with intermitting movement, like the slow, progressively-failing oscillations of the pendulum when the motor that impels it has ceased to act; moribund describes, in a word, the condition.

Bedford in that day was quite popular, and his methods at the bedside of the parturient woman were accepted without question. A suggestion of his in a case of the kind above described was to administer laudanum in heroic doses, in conjunction with brandy or not, in a teaspoonful dose.

Well, the tincture was administered in that dose and repeated, and afterward given at short intervals in diminished doses, till evidence of reaction was seen in the renewed manifestation of the vital functions. There was neither whisky nor brandy at hand. I was therefore obliged to put my trust entirely in the opiate. Whatever may have been Dr. Bedford's theory of the *modus operandi* of the drug in similar cases, and however contrary it may seem to certain preconceived notions concerning the physiological action of

opium, it does seem to possess marvellous stimulating powers in conditions characterized by great exhaustion resulting from vascular depletion. Its effects were truly magical. Early after its exhibition there were apparent signs of returning animation; first a slight, barely perceptible fluttering of the heart, a very faint, hardly appreciable vibratory thrill of the radial artery, and a faint sighing. But it was a long while before any hope could be reasonably indulged in.

At the end of a few hours the flickering flame of life had been so far restored as to afford ground to believe that, with careful nursing, future recovery was an assured fact. On the day following the wan, pallid, lifeless body of a few hours previous would scarcely have been recognized in the smiling countenance of the mother, happy in the possession of her infant, and the joyous congratulations of family and friends. It is almost marvellous with what rapidity return to strength and health is effected from conditions so perfectly similating death.

In conclusion I desire to call attention to the fact that in this instance life was saved through the prompt use of the readiest and most efficacious means at hand, namely, cold water. Other measures are urged as the most suitable in these desperate straits, such as the injection of hot or cold water, mixed or unmixed with vinegar, or some other astringent, or of a solution of persulphate of iron (Barnes), but the application of these demands delay, and during the time thus lost a few or many more ounces of blood will make all the difference in the world, and, through an unfortuitous concurrence of helpless nature and art, life ceases. If cold or iced water is not at hand, and hot water is, by all means use the syringe. Nothing, perhaps, could excel it in such an emergency. Should nothing better offer, introduce the hand into the uterus, make friction on its internal surface, while the other hand grasps the organ from without. An old practitioner assures me that this manœuvre succeeded admirably in a case of his, where he failed with other devices. However, in that class of appalling accidents where a moment's time lost may cost a life, if cold water can be procured—simply the cold douche—it will *rescue* life; although it must be confessed that it seems to be a rude and primitive method of application. True, a measure of effect, possibly enough in most instances, may be obtained by the use of cloths dipped in cold water and laid on the abdomen, to the thighs and vulva. But this lacks the additional force communicated by the fall of the liquid, a very important consideration. It may be urged that such practice should be discountenanced except as a *dernier ressort*, for the reason that if the lady and her friends could be consulted they would undoubtedly raise most serious objections. Let it be stated, *per contra*, that when the conflict is a hand-to-hand affair between the physician's method and the forces of the King of Terrors as to who shall have possession, it is no part of professional duty to stop to consider anybody's taste, inclinations or feelings, but to act at once, without unnecessary delay, and with all the intelligence at command, that, by the help of God, a life may be saved from almost certain dissolution. The writer has had occasion to use the douche on these occasions, and never with any misgivings as to the result. No evil was ever observed to follow it.

An aged practitioner, Dr. A. M. Ellsbury, informs me that he knows the method was a popular one over a hundred years ago. He was called to see a lady who was flooding severely, and used such applications as were in vogue at that time (1845), and known to him, then a young physician, but with little avail, when the mother-in-law, aged 96 years, told him that in her first labors she had copious hemorrhage, that her physician placed her in the recumbent dorsal posture on the hard floor, caused the nether extremities to be elevated, when he poured cold water on the vulva, then dashed it over the abdomen, and, lastly, all over the body. This was indeed primitive, but as the ancient great-great-great-grandmother truly averred, it accomplished the desired result effectually.

"In cases of extreme gravity, where the impression has been sudden and profound," my esteemed friend, Dr. W. W. Ellsbury, whose experience has been great, prefers to place reliance on the douche, yet in "cases not indicating such heroic treatment" he would make friction on the inner surface of the womb, while grasping the organ from without with the other. Of course it is not claimed that this would be the most desirable method in cases in which other and possibly less disagreeable means would answer equally well. Nor is it suggested by anything said above that an experienced practitioner would be guilty of the blunder of applying restoratives by the mouth or hypodermically before taking suitable steps to suppress the flow of blood; but, at the same time, let it be added that it is hoped the hint may not be lost on the young practitioner, who, although

his attainments may be excellent in their way, yet lacks bedside observation and the practical lessons thereby enforced. Arrest hemorrhage first, *then* use restoratives. Opium, as has been seen, is perhaps the best where there is great exhaustion; brandy, whisky or wine may be used to advantage. Ethereal preparations, by mouth or rectum, if practicable, or preferably given by hypodermic injection, are sometimes found very effectual in stimulating the respiratory centres. In cases where the indications are not so imperative, hot water injected into the uterine cavity is deservedly preeminent. Indeed, if it could be employed in those graver complications it would have to be considered the remedy *par excellence*.

A great advantage from its use is that relaxation does not subsequently occur, bringing a recurrence of the flooding, which is frequently the case after the injection of cold water or the introduction of ice. A simple, common-place device, and one oftentimes had recourse to by the country physician, is to carry the hand, grasping a sponge or folded cloth, saturated with strong cider vinegar, into the uterus; the sponge is squeezed, the vinegar flows around the wall, constricting the mouths of the open vessels. In all cases where it can be done firm external compression of the uterus should be made.

The question of shock might be raised. That is to say, that the douche as used is capable of inflicting a great shock on the already depressed and struggling powers of nature, and so precipitate the event it was designed to anticipate and preclude. It may be answered that, so far as known, instead of precipitating dissolution, it has in all instances, when applied in time, been the fortunate agent to avert that end. Doubtless the douche performs the two-fold function of an irritant (vital dynamic) and that of a mere physical dynamic. One eminent *accoucheur* whips the abdomen with a towel that has been dipped in cold or iced water, and to this innocent and effective mode it is objected that it could never be popularized in practice among the higher classes.

Can it be that the higher classes must be denied an advantage, a great boon it might be called, which their less favored sisters enjoy?

What became of the convulsions in the present case? There was but the one described; subsequently there were no signs of a recurrence. The history of eclampsia shows that frequently when convulsions take place under the circumstances alluded to there is but one, usually very severe. This doubtless was an example of the kind, for it is not probable that the chilling shock would have brought about a result contrary to knowledge and observation.

HEART DISTURBANCES IN CHILDREN DUE TO DISTENSION OF THE RIGHT AURICLE AND PULMONARY ARTERY.

BY JOHN M. KEATING, M.D.,
PHILADELPHIA.

In an interesting article by Martin de Gimard in the *Revue Mensuelle des Maladies de l'Enfance*, upon the relations existing between the right heart and diseases of the liver—an association as frequent as between those of the left heart and the kidney—there is the report of an interesting case, which may be summarized as follows: The subject was a boy 11 years old, who had hypertrophic cirrhosis of the liver without jaundice. There was nothing in the antecedent history of the case to attract attention. In 1887 an enlargement of the abdomen was noticed; the boy complained of a daily increasing difficulty in buttoning his pantaloons; and in addition, he had attacks of vomiting. These were the principal symptoms; another, which was brought out by questions, was that his face became deeply cyanosed after running from school; indeed, his father frequently scolded him "for getting ink on his lips." These symptoms increased rapidly, and the boy soon had slight panting after walking and some œdema of the lower limbs, and small quantities of albumin were found in his urine. Dr. Cadet de Gassicourt saw the case, and hesitated in his diagnosis between a primary affection of the heart and one of the liver. After a time the abdomen was tapped, and a large amount of fluid was evacuated; an enlargement of the liver was detected, and the diagnosis was established.[1]

The feature in this case which interests us most is the condition of the patient's heart. There was great dilatation of this organ, but there had never been a murmur while the child was in the house—though there was a marked clacking second sound over the area of the pulmonary artery—nor had there been any pulsation in the jugular veins. This case evidently represented a typical condition of cardiac enfeeblement and engorgement, with dilatation of the right heart, caused by a primary hepatic affection.

Gimard discusses the question of cardiac

[1] In the *Revue Mensuelle des Maladies de l'Enfance*, Laurent and Honoret have reported fifty-one cases of cirrhosis of the liver in children.

sounds in cases of hepatic cirrhosis, and quotes some observations of Laurent in his thesis on this subject. In one case of atrophic cirrhosis there was intense dyspnœa, double pulmonary congestion, and œdema of the lower limbs. In this case there was a systolic murmur over the aortic area, which was supposed to be dependent upon aortic stenosis; but at the autopsy *the valves were found normal*, and the right heart dilated and engorged. The post-mortem appearances in all the cases noted were similar.

There are so many conditions of the system which will produce cardiac weakness that it presents a most interesting study in children's practice. The affections of the right heart in children have scarcely received the attention they deserve, especially those which are functional.

In the ordinary position of the heart, a moderate degree of distension of the right auricle and ventricle will not cause any encroachment on the vessels as they are given off; but, if the right auricle becomes distended to any very great extent, in all probability a certain amount of pressure would

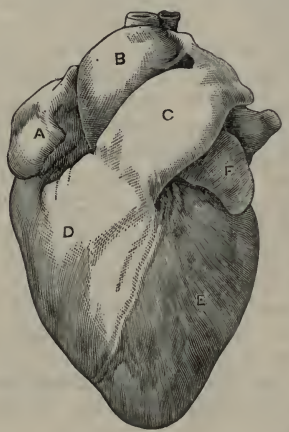

FIG. 1.

A. Right auricle. D. Right ventricle.
B. Aorta. E. Left ventricle.
C. Pulmonary artery. F. Left auricle.

be produced upon the aorta, and just at that portion where a constriction would cause a systolic murmur. This would be the more apt to take place if the pulmonary artery was also over-distended. As I look at a specimen which I have before me as I write, I cannot but feel convinced that the theory I have just offered in explanation of the systolic *bruit* in anæmic children, and in those in whom the heart-muscle is worn out or the nerves are toneless or exhausted, is tenable. A glance at the diagram which I have drawn from nature, I think, shows this condition.

Figure 1 represents an antero-posterior view of the heart, with the right auricle empty and the aorta of normal size.

In studying the specimen, I carefully distended the auricle and pulmonary artery with soft cotton, being careful not to over-distend it, but simply to fill out its relaxed tissue. I then placed the heart on edge, as it were, so as to show almost the whole right auricle except that portion behind the aorta. From

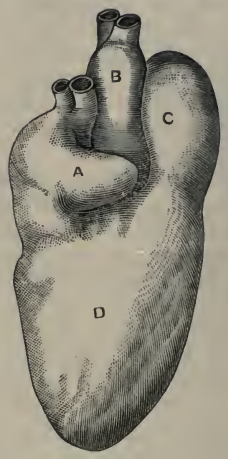

FIG. 2.

A. Right auricle. C. Pulmonary artery.
B. Aorta. D. Right ventricle.

this view, which is shown in Fig. 2, it will be seen that the aorta is distinctly narrowed in calibre by such distension of the vessels as I practised. This experiment has suggested to me the important question, Can the systolic murmur which is noted in the cases of Laurent, without any aortic lesion, and the enormous congestion of the right heart after death, be explained by the reciprocal pressure exerted by a distended auricle and a distended pulmonary artery?

My attention has been recently called to another peculiarity of the cardiac rhythm, which, though at first I believed it was confined to children, is, I am now satisfied, frequently found in nervous, worn-out hearts of anæmic adults, and especially of young women and young men.

This peculiarity consists in an irregularity in the impulse of the heart, which is dependent upon respiration, and is probably due to a choreic movement of the right heart when it finds itself deprived of its blood-contents by the sudden exit of its blood in expiration. The heart, in health and in the adult, is a well-toned muscle, capable of accommodating itself to all circumstances. In childhood, and especially in rapidly-growing children and cases of anæmia or chlorosis,

the heart-muscle keeps its tone when the stimulus of blood within its cavity is felt. As the air leaves the lungs, the pulmonary artery is called upon immediately to supply blood to its radicles, and when the heart is deprived of this stimulus, its action becomes at once excessively rapid and possibly irregular. During normal breathing, the heart's action will be noted as rather quick or possibly weak; when the breath is held, it will gain strength and be slower; but during forcible expiration it will become irregular, and possibly intermittent, and excessively rapid. I believe these phenomena to be, to a certain extent, normal in childhood; but when adults exhibit a *puerile heart*, it is undoubtedly an evidence of weakness of the heart-muscle—a weakness which is distinguishable from the ordinary functional disturbances of hearts under the influence of tobacco, and I believe particularly limited to the right heart.

TREATMENT OF RUPTURE OF THE PERINEUM.

BY ARTHUR E. SPOHN.
CORPUS CHRISTI, TEXAS.

This morning (October 21, 1887) I removed the stitches from the perineum of a patient upon whom I operated for ruptured perineum nine days ago, and found the result perfect. While the case is fresh in my mind, I have considered a short article on this operation not out of place. This subject has been so freely discussed in the journals lately that I almost hesitate to adding to the discussion the conclusions from my limited experience The fact that I have succeeded in securing admirable results by what I believe to be a new method of treatment, is the only apology I have to offer for this short article.

In the case in question the laceration was recent; the patient having been confined on the 9th of October of her first child. She was 30 years old, and her perineum was so rigid that I could not prevent a slight rupture. In regard to the case of the perineum, I have lately come to think the obstetrician should carefully watch the progress of the second stage of labor, exposing the parts to view. I have long since abandoned the practice of supporting the perineum, but I believe it is absolutely necessary to control the head of the child, and to direct the progress of labor so as to prevent a rupture of the parts. This can be done most successfully by bringing the occiput or chin, as the case may be, well forward under the pubic arch, and by holding the child's head back by well directed pressure until the perineum is slowly and successfully passed. If a perineum can be saved, I think this will do it. As an adjunct to the method, I invariably pour warm olive oil or vaseline into the vagina, between the pains, when the head is pressing against the perineum.

After the third stage of labor is completed, a careful examination should be made by thoroughly cleansing away all blood with a warm water antiseptic solution. For this purpose I prefer boracic acid. If, then, any rupture be detected, no matter how small it may be, it should be stitched up immediately; for in this, as in any other wound, the sooner the parts are nicely adjusted the better.

The following is the method I am now using, and I am pleased to say with perfect results: In a recent rupture, with the parts so much swollen that if the thighs are pressed together the perineum bulges forward, the deeper parts are firmly pressed together and the ruptured portion is really in good position to heal. This would, no doubt, often take place did not a clot of blood now and then sweep through, having irritating discharges in contact with the torn surfaces. But, bearing in mind the fact that this is very likely to happen, I treat these ruptures just as I would any other wound, by first irrigating the part with some antiseptic lotion; then, as soon as all bleeding has ceased, I stitch it up very carefully so that there is no gaping between the stitches and no point exposed to the discharges which must necessarily pass through the outlet of the vagina. I never insert deep sutures, and do not consider them necessary in cases of recent rupture. After washing out the vagina with a syringe, using hot water and boracic acid, I pass a pledget of raw cotton tied to a string into the vagina, carrying it well above the ruptured part. I use raw cotton because it will not absorb the blood or allow it to pass. I now irrigate the wound with the hot boracic acid solution until all hemorrhage ceases, and then adjust the mucous membrane nicely and stitch it carefully with silk thread, using an ordinary sewing needle. I next smear a little vaseline over the part, remove the cotton and wash out the vagina. This completes the operation, and the patient is afterward treated as if no rupture had taken place. I remove the stitches on the eighth or ninth day. In conclusion I may state that I always bathe the genitals of a lying-in woman, and wash out the vagina once or twice daily with a boracic acid solution and dust the parts with powdered boracic acid when ever any lesion has taken place.

Society Reports.

MEDICAL SOCIETY OF THE COUNTY OF NEW YORK.

Stated Meeting, January 23, 1888.

The President, Laurence Johnson, M.D., in the chair.

Dr. Daniel Lewis read a memoir of the late Dr. Wesley M. Carpenter, and offered resolutions, which were adopted.

Dr. Charles McBurney then read a paper on

External Perineal Urethrotomy as a Prevention of Complications after Operations upon the Urethra,

in which he said, that for some time he had been of the opinion that urethral fever was due almost, if not quite, always to septic infection. This view was supported by the fact that sepsis occurred more frequently in operations upon those portions of the urethra in which there was least opportunity for drainage. In the anterior pendulous portion of the urethra, blood and urine found their way easily toward the meatus, while posteriorly the flow by gravity, the patient lying upon his back, was in the opposite direction, toward the bladder. The best conditions for rapid absorption of septic material coming in contact with the wound, existed after division of the urethra. The treatment of diseases of the urethra by external urethrotomy had given good results. It seemed to him that the reason for success in these cases, and in operations on the anterior portion of the urethra, was that conditions favorable for drainage existed. The following conclusions were reached: 1. For all points not more than four inches and three-fourths from the meatus, internal cutting operations are best, and drainage will be sufficiently good for safety. 2. For all points farther from the meatus than four inches and three-fourths, cutting operations are also best, but the wounds here cannot drain properly and so be safe without a perineal opening. 3. External perineal urethrotomy is indicated in all cases in which, in the deep urethra, such conditions are present as may result in hemorrhage, septicæmia, urethro-perineal abscess, or infiltration of urine.

Dr. L. Bolton Bangs was in accord with all the author had said except that he believed some cases of urethral fever had a nervous element in them.

Dr. Robert Abbe thought that absorption of urine after operation upon the urethra might sometimes be the cause of blood poisoning, but it was his belief that in nearly all cases of urethral fever from sepsis, the poison was introduced from without by the operator. The difficulty of cleansing the urethrotome was great.

Dr. F. N. Otis related some cases illustrative of his view that urethral fever was not infrequently due to a reflex nerve influence. For instance, a certain patient always had urethral fever following instrumental interference with the urethra, except when he took quinine.

Dr. McBurney, in closing the discussion, said he could see no reason for excluding the cases related by Dr. Bangs and Dr. Otis from among those of urethral fever arising from sepsis. He did not like the term urethral fever.

Reports of Clinics.

COLLEGE OF PHYSICIANS AND SURGEONS.

MEDICAL CLINIC—PROF. DELAFIELD.

Hæmophilia.

The first patient brought before the class on January 5, 1888, was a boy of 9 years who had always been well until last year, when he was taken with bleeding from the gums, following the extraction of some teeth, the hemorrhage continuing for some twenty days. He has had no hemorrhage since then until Monday last, when he bled about a gill. On being stripped to the waist several areas of extravasation into the subcutaneous tissue of the forearm were noticed. He shows some malnutrition, the so-called chicken-breast, and a slight lateral curvature. The muscles are flabby but quite well developed. The mouth is in an unhealthy condition. According to the father's account there is no disposition to bleed in the branches of the family. Prof. Delafield remarked that a slight scratch is often followed by severe and prolonged bleeding in those affected with this disease, and referred to a case in which a cut of the face was followed by a profuse hemorrhage, the blood spurting for quite a distance. That the blood has sometimes been found to contain a deficiency of fibrin, and that the disease frequently runs in families, is about all one knows of the disease.

In the treatment of this affection, we succeed best in those cases in which a correction is needed. In this case the treat-

ment has reference to the improvement of the general health. With this object we will give him small doses of arsenic ($\frac{1}{80}$ of a grain), combined with ipecac. ($\frac{1}{6}$ grain), and iron (gr. ij) in pill form; one pill to be taken three times a day after meals; and give him also cod-liver oil in teaspoonful doses, gradually increasing the quantity to a tablespoonful three times a day. He must take no tea, no coffee, no pastry or sweetmeats, but plenty of bread and butter, meat and fresh vegetables. As regards mental strain we must restrict his school hours. He needs play, not study. To improve the condition of the gums he must brush his teeth twice a day with a boracic acid solution; and as for the ulcerated teeth it would be advisable to wait for their extraction until his condition is much more improved.

Stomachic Vertigo.

The patient, a rather stout man, complained of dizziness and a feeling of pricking and of contraction in the hands, two months ago. These attacks of vertigo were sometimes so severe that he would often have fallen if he had not grasped some object. Prof. Delafield remarked that it was not so very unusual for patients affected with vertigo to experience these peculiar subjective feelings. This patient had been placed on teaspoonful doses of Carlsbad salts in a tumbler of warm water every morning, and has steadily improved. He still suffers from slight digestive disturbances, yet his vertigo and the peculiar sensations in his hands have now entirely left him. Prof. Delafield said that he would now gradually diminish the amount of the Carlsbad salts until the patient takes nothing but his tumbler of warm water in the morning.

Malaria.

This patient's illness dates back fourteen months, when she was attacked with a pain in her left side, and on first awaking in the morning, difficulty of breathing, which was somewhat relieved on getting up and walking about. Since then she has had fevers nightly and a cough, which latter came on about a month later. The cough, though still continuing, has diminished greatly in frequency and severity. Since her illness she has lost flesh and strength. The physical examination yielded the following signs: Resonance and breathing good at both apices; heart's action rapid, but regular; radial pulse 120; no murmur.

"Gentlemen," said Dr. Delafield, "this patient is 43 years of age. Fourteen months ago she was attacked, when she awoke in the morning, with a pain in the left side, in the region of the heart, which became better after she had walked about a little. With this she had shortness of breath. Every evening she feels hot and feverish. After the lapse of a month the pain in her side ceased. At this time she began to cough, and with this cough she has had mucous expectoration, which has been at times stained with a little blood. The fever still continues nightly, and she has lost flesh. Her appetite is not good, but there is no nausea, and she is afflicted with habitual constipation. She does not look so bad, and the physical examination shows a good condition of both lungs. The pulse is rapid, but regular, and there is no murmur. What is the matter with her?"

If the disease is chronic miliary tuberculosis it is not sufficiently advanced to give any physical signs. And as far as malaria with a chronic bronchitis is concerned, if it is that, it must be an irregular form. Of the two I am inclined to think it an irregular form of malaria. The treatment, however, will show, although these forms of malaria are difficult of treatment. We shall give her, then, two grains of quinine three times a day, after meals, with two grains of antifebrin in capsules, followed by twenty drops of dilute hydrochloric acid in water. The constipation should be relieved, and for that purpose two teaspoonfuls of Carlsbad salts before breakfast, in a tumblerful of water, will be ordered. Though the fever does not leave immediately, these patients will at least improve, eat better and feel better generally.

Broncho-Pneumonia.

This patient has been sick but three or four days. He is taken ill every winter, at about the same time of the year (January), with an attack like the present one. When the attack comes on, he has a feeling of pain and "eating" in his left side. On going to bed his cough is so severe that he is compelled to sit up all night, and it is accompanied with cold sweats and fever, and shortness of breath. He has no headache, and his bowels are regular; the tongue is coated, the appetite lost. He is a large, muscular man, with a good, well-formed chest. The resonance over his chest, however, is not good; the quality is changed, especially over the left and right upper sides; it is not pulmonary in character. Auscultation reveals a prolonged expiration, sonorous and sibilant breathing; sibilant râles in the lower part of the chest, and something like friction sounds

are present. The heart's action is regular, and there is no murmur. Behind, a few sub-crepitant râles are detected; the breathing is not so distinct. There is no difference in the vocal fremitus.

"The patient is 22 years of age, and robust. Every winter he has attacks which last about two weeks. The pulse is 100, temperature 100°. Percussion reveals an emphysema, and he has attacks of acute bronchitis with his moderate amount of emphysema. Why should this man be so sick; more sick than is to be expected by his symptoms or signs, or from his looks? To account for his condition it is necessary to look further. The rule is, to expect to find a broncho-pneumonia. You may not get the physical signs of this disease, and these signs are not here. We will put dry cups all over his chest, every day for three or four days, and later we will give him ipecac and quinine. Now we will give him a preparation with opium and send him home."

GENITO-URINARY CLINIC—PROF. OTIS.

Retention of Urine.

At his clinic held on January 5, 1888, Prof. Otis remarked:

At our last lecture we considered some of the causes giving rise to the retention of urine. To-day we will continue this subject. Gonorrhœa is followed by various accidents, the most important of which is a deposit of plastic matter in and around the mucous membrane in the sub-mucous areolar tissue, followed by its consolidation and resulting in the contraction of the calibre of the urethra Sooner or later we have following this progressive narrowing of the canal a retention of the urine. In retention from prostatic trouble, I showed you how to pass instruments, and also the embarrassments with which the surgeon was likely to meet. As, however, enlargement of the prostate is frequently met with in old people, I think you should be perfectly familiar with the methods of examination, onset of symptoms, etc., and shall therefore limit my remarks to this subject to-day.

We have late in life, in a considerable proportion of men, difficulty in urination. This difficulty is met with in about one in fifteen or twenty; in a lesser proportion the difficulty is more severe, and yet may not call for interference; but in a certain proportion of all old men, and those over 55, the difficulty is met with to such a degree as to call for instrumental interference. The first thing that is noticed is sometimes a little frequency in urination, which attracts the attention of old men more than anything else. He may rise at first perhaps but two or three times. Going on with these symptoms for a year or two, he finds at last that he cannot urinate at all. Then his physician is called, who will at once suspect the trouble. True, the difficulty may arise from a stricture of the urethra. The first thing to be done in these cases is to examine the prostate per rectum. We have here a patient who might give us some new symptoms. His age is about 67, and he has had this difficulty seven or eight years. In patients 55 or over, with difficulty of urination, you must look for prostatic trouble. This patient has had to get up at night to urinate. He says he has never had gonorrhœa, but the urethra had discharged a little.

Prof. Otis here mentioned several cases in his practice, in which the patients, when asked, denied all knowledge of ever having had gonorrhœa or any other disease, and cautioned the class to ascertain this fact if possible, as it was sometimes important to know.

Later, this patient was obliged to get up a little oftener, until finally the flow stopped altogether. Upon close questioning it was ascertained that the retention occurred after drinking rather freely of beer. This excessive indulgence in drinking is often followed by a sudden stoppage of urine, and is due to either an overdistention of the bladder or to a spasm of the urethra. The urine becoming changed in character, irritates the parts, which in consequence become more sensitive, and finally blunt reflex action. This condition, giving rise to inflammatory swelling and thickening, is followed by retention.

The patient sending for a physician then, the urine was drawn off. Early detection and relief of this retention is important, for a few hours even may damage the structure of the bladder.

Dr. Otis here referred to the case of a patient who went to bed at night after a carousal, and found, the morning following, that he could not urinate. This result, according to Dr. Otis, was due to an over-distention.

The distinction between cases of atony and non-atony is quite apparent. In cases of atony the urine will dribble from the catheter drop by drop; in cases of non-atony the stream can be increased at will. The amount of urine contained in the bladder varies. In some cases, especially in those who have had several attacks of inflammation, the bladder holds a pint, and in other cases a quart. In drawing off the urine, do it with considerable care, especially in those cases in which

the accumulation has taken place in twelve or twenty-four hours, or when the accumulation is large, as a fatal syncope may follow a too sudden withdrawal. A cystitis may also follow a too sudden withdrawal of the urine. Urethral fever may occur after the introduction of a catheter for the first time, and may be fatal. Be careful, therefore, in the introduction of the catheter, and after its introduction give a suppository of quinine and morphine, and order rest for the next twenty-four to thirty-six hours. If these cases were rare I would not so seriously dwell upon the subject; but they are *not* rare. In urethral fever the temperature may run up more or less rapidly to 104° or 105° F., and appear as a malaria; these cases are not so much to be feared. But when the temperature gradually runs up after the introduction of the catheter, you may look for trouble. In fatal cases of urethral fever we often find that the patient has had some kidney trouble.

Prof. Otis recommended the students to read the remarks on "Catheter Fever," by Sir Andrew Clark, as published in the *Lancet* some four years ago. He also mentioned the case of a man who was subject to slight attacks of retention, and who referred such attacks to hemorrhoids, from which he was at times a sufferer. This man positively refused to see a physician about his trouble, even at the strong solicitation of his wife and son. He was taken with an attack just prior to his going upon a fishing excursion, but again refused to see a physician, and moreover, insisted upon making the trip. A few days thereafter, however, his suffering became so severe that he at last consented to see a physician upon his arrival at Quebec. The delay, however, was fatal, as he died on his way to Quebec, eight days after leaving home.

In drawing off the urine, then, never allow the bladder to be completely emptied, especially when it is greatly distended, but draw off just enough to relieve the distended organ and the urgent symptoms—about a pint is generally sufficient—and immediately teach your patient to draw off his own water. If the urine be decomposed, antiseptics may be necessary. In that case draw off about half a pint more, and supply its place with a saturated boracic acid solution. In five or six hours repeat the experiment, and thus *gradually* empty the bladder.

The patient, whose presence was the occasion of these remarks, upon rectal examination was found to have a bilobed prostate of the size of a good sized lemon.

Periscope.

Ophthalmia of New-born Children.

In the January number of the *Medical Chronicle* is published a translation of an essay by Dr. P. H. Mules, Surgeon to the Manchester Eye Hospital, on ophthalmia neonatorum, which essay was awarded the prize by the "Parisian Society for the Protection of Infant Life." After giving some interesting statistics which show that the disease is decreasing in frequency, the author defines the disease in question as "a blennorrhœal disease of the palpebral conjunctiva of a new-born or comparatively new-born child." The period of incubation is stated to be about fifty hours, occasionally much less, varying with the potency of the infecting material. When infection is prolonged to three or four days, the reason is doubtless the feeble infecting power of the material, or unusual resistance on the part of the conjunctiva. If it occurs after the fifth day, it may be accepted as positive proof that secondary inoculation has taken place.

Primary conjunctival inoculation takes place by one of the following methods:

1. In utero with a face presentation, the obstetrician transmitting the infection on his finger during examination. Should the birth be delayed, it is conceivable that the infant might be born with the disease developed. 2. By the application of instruments to expedite birth, the eyelids being accidentally opened by their use; a more probable mode of infection than the preceding. 3. By the retention of contagious muco-pus upon the child's eyelids after birth, and its subsequent inoculation by the natural movements of hands, eyelids, etc., the use of a dirty sponge, or careless handling on the part of the nurse at the first washing. 4. By the direct introduction of contagious muco-pus into the eyes by the edge of the perineum.

Secondary inoculation may occur through one of the following methods:

1. By not wiping out the eyes of the child at birth. 2. By using unclean linen or other material for the purpose of cleansing the eyes. 3. By using the same water for the head and face that has been used for the body and limbs. 4. By neglecting the use of a disinfectant to the child's eyes when vaginal discharge is known to have been present in the mother before the birth. 5. By using the same sponge to cleanse the face of the infant that has been used to the maternal passages. N.B.—The risk of inoculation is enormously increased by neglecting to re-

move infected lochia by syringing. 6. By not washing the hands after adjusting and washing the mother before washing and dressing the child. 7. By using the same water, cleansing material, or sponge to a healthy infant that has been used to one affected with ophthalmia neonatorum. 8. By the fingers of the mother, if suffering from vaginitis. 9. By overcrowding, thus favoring extension of the disease. 10. By want of isolation, the healthy and diseased being allowed to mix indiscriminately together.

The treatment, which the author divides into preventive and curative, and gives *in extenso*, may be summed up by saying that all cases of vaginal discharge should be cured before labor begins by means of suitable local applications; that the vagina should be irrigated, during the second stage of labor, with a solution of bichloride of mercury (1–2000); and the utmost cleanliness should be used in washing the child, and the greatest care in protecting its eyes from all irritants, including light and draughts of air. When the disease is once developed, Dr. Mules strongly recommends Von Graefe's plan of treatment, and says:

The mother or nurse should first wash the eyes in warm water to remove the secretion and free the lids. The surgeon should be seated in a convenient chair, with a folded towel across his knees, and with medical appliances within reach of his hand. These appliances are: (1) A plentiful supply of pieces of clean rag; (2) Solutions of argenti. nit., 5 gr. to 1 oz. and 10 gr. to 1 oz.; (3) Vessel of clean water; (4) Two camel-hair pencils to apply the solutions and wash the excess of fluid away; (5) A bottle of eserine, 5 gr. to 1 oz., and dropper; (6) Lid elevators. He then receives the head between his knees, yet supported by the towel. The nurse, tucking the child's legs under her left arm, supports the body on her raised knee, holds the child's hand with one hand, and has the other at liberty to assist the surgeon. The surgeon first proceeds to examine the condition of the cornea by gently raising the upper lid with his finger; if there be any difficulty in this manœuvre he uses an elevator. A bent hair pin often answers admirably. He next everts the lids, wipes them dry, paints them with the silver solution of the required strength, taking special care to get to the *back folds of the conjunctiva*, and, washing off the excess of solution with clean water, carefully replaces the lids by drawing them downwards and away from the globe. This process is repeated by the surgeon every morning until the disease is arrested, his object being to produce a slight eschar, which either destroys the micro-organisms or prevents their multiplication. The effect lasts about twelve hours. In severe cases the solution can be reapplied at night. However careful the surgeon may be, his efforts are of little avail unless he be ably seconded by the nurse. Her duties are to prevent the recollection of pus by constantly opening the lids and wiping the matter away with clean rags; to wash the conjunctivæ with a weak alum or boracic acid solution, 3 gr. to 1 oz.; to anoint the lid margin with cerate to prevent adherence, and to combat the feverish restlessness by fresh air and careful attention to diet.

For the treatment of the complications of ophthalmia neonatorum, we refer our readers to the original paper.

The Influence of Naphthalin upon the Eye.

Dor, Panas and others have observed a series of interesting changes in the eyes of rabbits after the animals have been fed with naphthalin. E. Magnus has repeated these experiments, and has recorded the results of his observations in the *Therapeutische Monatshefte*, No. 10, 1887. From an abstract of this paper in the *Centralblatt f. d. med. Wissensch.*, Dec. 24, 1887, we learn that Magnus gave the animals from 7½ to 22½ grains of naphthalin a day. After some time there were found in the retina, scattered over the whole eye ground, numerous glistening, white specs, and also large yellowish white plaques, which were particularly thick at the optic nerve. At the optic nerve, likewise, appeared small whitish specs, which soon filled up the excavation about the optic nerve, which is so characteristic in rabbits. Also in the vitreous there appeared, but only in individual instances, single clear, brilliant opacities, like crystals of cholesterine. In the lens were found at first shadowy streaks, then there developed opacities, which formed first on the posterior surface of the lens, in the form of spider's webs. These increased in size with striking rapidity, so that in a short time the entire posterior surface of the lens seemed totally opaque. Radiating streaks ran from the posterior to the anterior surface, and finally developed on the anterior surface of the lens into an opacity which was analogous to that on the posterior surface. The nucleus and the perinuclear layers always remained free. The cataract at times also appeared first, and therefore could not be due to an affection of the retina, but must be caused by the direct action of the naphthalin alone. In the author's opinion the naph-

thalin causes a chemical combination of the nutritive fluids of the lens, which excite a process in the lens similar to inflammation. Besides this, parenchymatous nephritis occurred in all the animals.

Trephining for Meningeal Hemorrhage.

The *Lancet*, December 24, 1887, states that a woman, 26 years old, was admitted in a semi-comatose condition to St. Thomas' Hospital, under the care of Mr. Croft, about midnight, on December 11. She was supposed to have been knocked down and kicked by a horse. There was a scalp wound, not leading down to bone, behind and below the left parietal eminence, and no evidence of fracture. During the night she passed into a state of absolute coma, and in the morning had complete paralysis of the right arm and leg, but not of the face. Mr Croft trephined in the situation of the wound, and removed about two ounces and a half of somewhat granular clot, which was spread out for some distance between the dura mater and the bone. The hemorrhage was from some vessels in the dura mater (probably posterior branches of the middle meningeal), and could only be arrested by means of pressure. About six hours later the power of movement returned in the right side, and her condition gradually improved. She spoke for the first time after the injury on the 13th. Although not yet recovered, she is still restless at times and impatient of control; there is no paralysis, the wound is quite aseptic and healing, and the improvement continuous. A severe contusion of the groin was, however, followed by sloughing and cellulitis, for which incisions were required.

Poisoning with Corrosive Sublimate.

At a recent meeting of the Berlin Medical Society (*Deutsche med. Wochenschr.*, Dec. 1, 1887), Prof. Virchow demonstrated preparations from thirteen fatal cases of corrosive sublimate poisoning. In all of the cases solutions of the bichloride of mercury had been used externally in various amounts, and in all there were intestinal lesions, which Virchow was scarcely able to distinguish from those of true diphtheritic dysentery. Two of the most severe cases were those of puerperal women, whose vaginas had been washed out with solutions of bichloride in amounts not stated. Another case, in which only the early stage of inflammation of the intestines was present, was that of a man under treatment with the bichloride of mercury for syphilis.

The localization and anatomical features of all the cases were precisely those of dysentery. To offset the not unreasonable doubt that such processes could originate by means of the circulation—for in no case was the mercury introduced directly into the intestine—Virchow referred to early experiments of Liebreich, who had produced similar lesions in rabbits by poisoning with corrosive sublimate. In one of Virchow's cases mercury could be found in the affected intestine, and in the hemorrhagic spots in the latter were colonies of micrococci. It appeared to Virchow as if the sublimate had caused an intense irritation, which so changed the tissues that they presented favorable conditions to the bacteria in the intestines to settle in them.

In the discussion which followed, Senator mentioned a case in which internal use of bichloride caused remarkable changes in the lower bowel, while the stomach and small intestines were but little affected. This favored the theory of a circulatory origin of the process.

In these cases the amount and concentration of the solutions used are not given. It may not be superfluous to call attention here to the fact that sublimate poisoning does not depend at all on these factors. In Breisky's wards in the Vienna General Hospital, bichloride has given place to carbolic acid as a vaginal douche, five cases of intoxication having followed the use of 1 to 4000 solution in the other obstetric clinics in the same institution, and diarrhœas of more or less severity are common among the assistants and midwives who use a 1 to 2000 solution on the hands.

On the Limitations of the So-called "Wier-Mitchell" Treatment.

In the *Lancet*, January 7, 1888, Professor W. S. Playfair, who was the first to advocate the Wier Mitchell treatment in England, and who speaks of it as "the greatest advance of which practical medicine can boast within the last quarter of a century," publishes a communication, in which he endeavors to state the limitations of this method of treatment, and the precautions which should be taken in the selection of cases in which it is to be applied.

1. In the first place he lays down the rule, which he thinks is subject possibly to a few rare exceptions, that it is unsuited to any form of organic disease. Such a disease is locomotor ataxia. He admits that there are cases of obscure spinal disease in which it is almost impossible to tell whether the disease is functional or organic, and will

even go so far as to say that there are some cases of this kind whose nature can only be solved by submitting them to the test of this treatment. He advises that the practitioner, when in doubt, should consult a specialist in nervous diseases before undertaking the treatment.

2. In the second place, care should be taken never to apply this treatment to any marked case of mental disease. He thinks this method has often been attempted in cases of pronounced melancholia and other types of chronic insanity, in which it cannot possibly do any good, and in which it may do much harm. Strong pressure is often brought to bear by relatives and friends to have a case pronounced "hysterical," because they cannot bring themselves to face the fact that it is mental.

3. In the third place, he strongly urges every one contemplating the treatment of a case in this way, either to do it thoroughly and well, or not to do it at all. He thinks that many hopeful cases have been spoiled because the practitioner tries the method "in a modified way," the modification generally consisting in treating the patient in her own house, or in admitting the visits of friends, or in allowing the patient to get up and go out during treatment. Increasing experience has convinced him that thoroughness and completeness are absolutely essential, and should be considered a *sine qua non*. If they are neglected, failure may most certainly be predicted.

The Treatment of Laryngeal Phthisis.

At the meeting of Leeds and West Riding Medico-Chirurgical Society, Dec. 2, 1887, Dr. Ernest Jacob gave a *résumé* (*Lancet*, Jan. 7, 1888) of the methods in use among laryngologists for the treatment of tubercular disease of the larynx. He spoke of the difficulty of diagnosis, in the earlier stages, between a simple catarrhal condition capable of cure and the severer form in which tubercular infiltration and ulceration were found. Cases had been recorded in which the laryngeal affection was primary, and the lungs not at all affected; but in most cases the pulmonary lesions could be detected first. He had been in the habit of suspecting tuberculosis in all cases of catarrh which did not yield to treatment. In the early stages mineral astringents, especially iron, were of use; but in the later stages he strongly recommended insufflations of iodoform, iodol, and boracic acid, with or without one-quarter or one-sixth of a grain of morphia, according to circumstances. In the distressing dysphagia which formed so prominent a symptom in later stages, relief to pain could be given by insufflation of morphia mixed with starch shortly before a meal, or a spray of cocaine; the latter, however, should be given with an apparatus reaching nearly to the entrance of the larynx, as otherwise most of the drug was wasted on the pharynx. He had not found lactic acid of much use, and thought tracheotomy should be deferred as late as possible.

The Question of the Infectiousness of Tertiary Syphilis.

Dr. Maximilian V. Zeissl says in the *Intern. klin. Rundschau* that the following points may be made against the inoculability and transmissibility of the products of tertiary syphilis: (1) Patients with tertiary syphilis as a rule beget healthy children; (2) the secretion of a disintegrated initial lesion and the products of the papular stage of syphilis produces a re-infection of syphilis in those affected with gummata; (3) inoculations with the secretion of gummata are never successful.

In favor of the infectiousness of tertiary syphilis are the following points: (1) It has been proved by several authors, that tertiary syphilis is transmissible, although this occurs with extreme rarity; it probably depends upon the length of time which has elapsed since the primary affection of the parents. On the other hand, it is not absolutely necessary that syphilitic parents should beget syphilitic children, for it has been proved that even parents with secondary syphilis may beget healthy children. (2) There have been hitherto but very few cases of re-infection of syphilis in persons with tertiary syphilis, and even these few are open to doubt, as in them the course of the syphilis acquired for the second time was quite abnormal. (3) Inoculations with the secretion of tertiary syphilitic products are up to the present time but few, and negative results are never demonstrative; this is seen from the fact that even inoculations with the secretion of primary and secondary syphilitic products are frequently unsuccessful.

In addition to the points just made, the author adds that an additional fact in favor of the infectiousness of the tertiary syphilitic products, is that they have the same histological structure as the papule and the chancre. The positive proof of the existence of syphilis bacilli will also throw light upon this question. The question cannot yet be decided.—*Deutsche Medizinal-Zeitung*, December 15, 1887.

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DRINKING WATER AND TYPHOID FEVER.

The relation of drinking water to the production of typhoid fever, is one of the most important subjects which can engage the attention of physicians and sanitarians. It is commonly believed, and with much show of reason, that typhoid fever is caused by the ingestion of a poision of a chemical or of a biological character—a virus or a germ. This belief is, we say, plausible, and yet it is not, so far, placed beyond a reasonable doubt. There are authors whose study of cases occurring under their own observation, and of others reported by intelligent and conscientious observers, lead them to the belief that typhoid fever is an auto-intoxication due to the putrefaction of ingesta in themselves originally innocent—what has been aptly termed a "fecal intoxication."

However this may be, there can be no denial of the fact that many cases of typhoid fever seem to be explicable upon the former theory, namely, that they are caused by the ingestion of a definite poison or of a specific germ. Furthermore, there is sufficient reason for believing that the poison or germ is usually introduced into the human body in milk or water; and that when it is introduced in milk, its presence is to be attributed to the fact that the milk has received an admixture of polluted water. Thus, in the end, it is the water which is suspected, and it becomes a very serious question, whether or not drinking water is a usual vehicle for the contagion of typhoid fever.

Unfortunately for the cause of science, and for the good of humanity, this question cannot be answered positively at the present time. As has already been intimated, there is much to support an answer in the affirmative. A recent discussion at the Society of Public Medicine and of Professional Hygiene, of Paris, indicates the uncertainties which surround this question, and at the same time shows that the general drift of medical opinion is toward the conviction that an impure drinking water is a frequent cause of epidemics of typhoid fever. We have had our own experiences in America, in which well-studied local epidemics have been traced with seeming reason to the pollution of streams or of wells, with the excreta of typhoid fever; and others in which they have been attributed to impurities in drinking water which were not of a demonstrable specific character. The former source of danger need not be dilated on; the latter demands the most earnest thought from all who are interested in preventive medicine.

So far as we know, no connection has been traced, logically and incontrovertibly, between the water supply of any large city in America and the prevalence of typhoid fever. A vigorous attempt has been made to do this in the case of Philadelphia; but, although this attempt has engaged the co-operation of a weathy corporation, which had every reason to demonstrate the evil character of the drinking water of this city, the attempt has so far utterly failed.

In Europe e case is different. In one city, at least, experience of recent years indicates that an impure river water may have been chargeable with a considerable proportion of the cases of typhoid fever occurring there. This city is Vienna, where the almost total abandonment of the Danube, as a source

of water supply, and the introduction of water from a distance and from an elevation considerably higher than that of the city, has been followed by a notable decrease in the number of cases of typhoid fever. This evidence—although it is of a negative sort, it must be remembered—is very strong; and it certainly makes it reasonable to assert that the use of the water of the Danube was formerly the cause of many cases of typhoid fever in Vienna.

An attempt has been made to show that the use of the water from the Seine has had a similar result in Paris. But this is not so clearly established. The most that can be said in regard to it is, that there is fairly good evidence that it is true.

We are not aware that any other deductions, on so large a scale, have been made for other civilized cities; and we are of the opinion that the question of the relation of the drinking water of large cities to the production of typhoid fever is not yet definitely settled. The most that can be said positively by those who have at heart the purity of their drinking water is, that experience shows it to be important that every effort should be made to exclude the possibility of infection by this means; and that an impure water certainly facilitates, if it does not originate, the development of typhoid fever.

Such a temperate statement of the case justifies a careful investigation of any suspected source of water supply, and the adoption of any practicable measures to secure for the inhabitants of a town a water supply which is above suspicion. Such investigations, however, must be candid as well as thorough, and such measures must be adopted with no other object than the good of those for whose benefit they are proposed. Meanwhile it is of the utmost importance, as is remarked by the *Gazette Hebdomadaire*, of Paris, January 13, 1888, that epidemics of typhoid fever should be subjected to thorough scientific investigation; for it is unfortunate that uncertainty should continue in regard to the etiology and prophylaxis of a disease so common and of such grave consequences to public health.

PRESCRIBING BY DRUGGISTS.

In a recent number of the *National Druggist*, Mr. James Kennedy has an article in which he defends druggists against the charge of indiscriminate counter-prescribing, and says some things which ought to be considered, in fairness to druggists and for the good of physicians. We have no doubt that the evils of counter-prescribing are sometimes exaggerated by physicians, and that the latter sometimes expect too much of druggists, in the way of sending truant patients back to them. Nevertheless, the practice of counter prescribing is one which needs very careful watching to prevent it from being a damage not only to the income of medical men, but also to the health of the community. It seems fair enough for a druggist to say that he cannot send to a physician every one who asks him for a remedy for constipation or a cold; but this claim overlooks the most important feature of these cases, namely: that both patient and druggist assume that a correct diagnosis has been made by one or two persons, neither of whom has any training in this most difficult branch of medical science.

Fortunately for mankind, a great many of the ills to which flesh is heir tend to disappear of themselves, and many of the drugs which are prescribed over the counter do no harm, even if they do no good. But we have known a number of cases in which serious errors of diagnosis or of treatment have been made by druggists. We have known syphilis to be mistaken for gonorrhœa, and scarlatina for measles. And we have seen iodism and cinchonism pushed to a dangerous point in the misguided therapeusis of men who have assumed the *rôle* of the physician without the necessary training or experience.

Within a short time we have known of a case in which a mother diagnosticated an eruption as that of measles, and a druggist's clerk confirmed the diagnosis, and said it was not necessary to apply to a physician. After this, the mother and the druggist's clerk agreed upon a line of treatment which included sponging the child's body with alco-

hol and water, without any precautions against cold; and only good fortune saved them from a disaster, for the child had scarlet fever!

For reasons suggested by a case of this sort, we think that druggists might well fix their minds more on the risks of counter-prescribing than upon what they may regard as unreasonable demands on the part of medical men. No doubt those who compound the prescriptions of competent physicians pick up a smattering of knowledge as to the uses of medicines; but those who know by experience how delicate and how difficult a matter it sometimes is to make a correct diagnosis in regard to an apparently simple ailment, cannot regard with approval the assumption, inseparable from the practice of counter-prescribing, that a druggist is a trustworthy diagnostician.

ANTIPYRIN AS A HÆMOSTATIC.

It often happens that a drug introduced into practice for one purpose soon demonstrates its applicability to others, so that its field of usefulness is changed or enlarged as time passes. The most recent illustration of this is to be found in antipyrin, the value of which in neuralgic affections bids fair to rival its value in reducing abnormally high temperature. And now it appears in a new *rôle*.

At a meeting of the Société de Biologie, of Paris, January 7, 1888, M. A. Henocque calls attention to the fact that in December, 1884, he described a hæmostatic influence of antipyrin which he has since demonstrated more completely, and which has been confirmed by other and independent observers. His own experiments indicate that antipyrin, in powder or in solution, produces constriction of the blood-vessels when applied to them directly. This view is opposed to that of Caravias and Gley, who believed that antipyrin dilates the blood-vessels; but it seems to be proved by the experience of Hénocque.

This fact is so important that it appears worth while to describe the way in which Hénocque uses antipyrin as a hæmostatic. He employs it in powder, in solution, or incorporated in an ointment or pomade. Used in powder it is applied directly to a wound, and is covered with a dry dressing of cotton or charpie. For epistaxis the powder can be snuffed up the nose; for hemorrhage from the uterus it can be applied to the cervix or to the cavity of the uterus upon a suitable tampon. For wounds he generally uses a wash containing five per cent. of antipyrin; but for deep cavities, like the nose, he thinks a twenty per cent. solution should be used. In practice he finds it convenient to use sterilized cotton or filter paper, soaked in a strong solution of antipyrin and then dried, which can be applied to a wounded surface either dry or after soaking in boiled water.

In a case of cancerous ulceration of the breast now under his care, he has used with the best results a pomade made of one part of antipyrin with three parts of vaseline (cosmoline would serve as well) rubbed into cotton cut into small segments, to make it more coherent. This he applies to the surface; when it is to be removed he loosens it with a wash containing one per cent. of antipyrin, so as to prevent hemorrhage. He changes the dressing only twice a week, and finds that it has, in this case, put an end to suppuration and to the characteristic odor of cancer.

When it is borne in mind that antipyrin is an antiseptic, it will be seen that the fact that it has hæmostatic properties also, makes it a valuable addition to the armamentarium of the surgeon and of the general practitioner.

HUMANE EXECUTIONS.

The *New Yorker Med. Presse* for January, 1888, points a keen shaft at the endeavor which is being made in various places, and most strenuously in New York, to change the method of executing criminals condemned to death, from hanging to some other way. One of the points which our contemporary makes is that this endeavor is an attempt to make humane an utterly inhumane thing. This is very true; and we share the opinion that it is a questionable

course to try to improve on the method of execution now employed in English-speaking countries.

There is no evidence that hanging causes much suffering to its victim, and there is not a little that it does not. Other methods, such as killing with electricity, or with poison, may appeal to our sentiment, but they have disadvantages which must be strongly opposed by a calm judgment. Their most important disadvantage lies in the fact that they would deprive legal executions of one of their most important objects, namely: to deter others from committing crimes punishable with death. The very fact that a legal execution is not designed to give a criminal an easy and pleasant exit from this world has some influence upon the vicious—how much, it is hard to say. But who can tell what would be the effect of robbing the law of its terrors, and of teaching brutal men, who have no thought of another world or a future judgment—especially in an age which has refined the fear of this judgment almost to the vanishing point—that when the law demands a life for a life it will deal out to the dispenser of a bloody and cruel death, euthanasia?

No thinking man would sanction needless cruelty to one who must suffer the extreme penalty of the law; but we believe that a thinking man may well consider all the possible consequences of making legal executions wholly painless and free from horror, before he permits himself to become committed to an attitude in regard to them, justified only by reasons which, if carried to their natural conclusion, would abolish the death penalty altogether.

Certainly, in this country the law's delays and the tendency to treat condemned criminals as martyrs, which has had so many and so recent illustrations, leave little to impress brutal men with the enormity of the crime of murder; and, though hanging be a dreadful thing, we cannot see any good reason for choosing a less dreadful way of punishing those whom the limitations of human power make it necessary to visit with death for their crimes.

THE OBSTETRIC FORCEPS.

In a note in the London *Lancet*, Dec. 31, 1887, the free use of the revolver is compared with the free use of the obstetric forceps; and the statement is made that the pernicious habit of carrying a pistol reminds the writer of the observation made by old obstetric writers, that carrying forceps in the pocket very much increases the temptation to use them. This is a fact; and, although it cannot be denied that the forceps are often useful and sometimes indispensable, we believe that the use of them is likely to become a habit, unless great care can be taken to prevent this.

We know of a medical man who, in more than ten years of general practice, had the good fortune to never own a pair of obstetric forceps, and to really need them but once; on which occasion he sent for a friend and his forceps, and just before they arrived the baby was safely delivered in the natural way.

REMEDY FOR EPITHELIOMA.

In the *Deutsche med. Wochenschrift*, December 1, 1887, Dr. Bidder strongly recommends the application to carcinoma of the skin, or uterus, of a powder composed of equal parts of powdered savin and burnt alum. Its application to the skin is made by rubbing it on the new growth, upon which it will act without affecting the sound tissues. In case of epithelioma of the vaginal portion of the cervix uteri, it can be applied through a speculum and kept in place by a small tampon of cotton or wool. Used in this way, it lessens hemorrhage, diminishes fever, and relieves pain. Dr. Bidder even thinks that it might affect a cure in cases in which the disease has not made much progress.

—A meeting of the commissioners appointed to investigate and report to the Legislature the most humane and practical method for carrying into effect the sentence of death in capital cases was held at Albany, Jan. 9. The commission has received, a letter from a French mechanic who thinks the electric method to be a painful operation, and offers a device which consists of a chair, in which the condemned man sits while his spinal column is immediately broken.

Pamphlet Notices.

The Radical Treatment of Trachoma. By A. E. Prince, M.D., Wabash, Ill. From *St. Louis Courier of Medicine.* 7 pp.

Wounds, their Aseptic and Antiseptic Management. By David Prince, M.D., Jacksonville, Ill. A paper prepared for the meeting of the American Surgical Association, 1887. 16 pp.

Treatment of Chronic Suppurative Otitis Media. By Seth S. Bishop, M.D., Chicago. From the *Journal of the American Medical Association*, Dec. 3, 1887. 4 pp.

Operations for Mastoid Disease. By Seth S. Bishop, M.D., Chicago. From the *Journal of the American Medical Association*, Nov. 12, 1887. 8 pp.

Statistical Report of 5700 Cases of Ear Disease. By S. S. Bishop, M.D., Chicago. From the *Journal of the American Medical Association*, December 17, 1887. 7 pp.

Babies and their Troubles. By Charles L. Gwyn, M.D., Galveston, Texas. From the *Transactions of the Texas State Medical Association*, 1886. 8 pp.

—Dr. A. E. Prince's paper was read before the Central Illinois District Medical Society, as long ago as October 19, 1886. It contains a defense of the method adopted in 1881 by Dr. Hotz, but brought forward as a method first by Mandelstam, of Moscow, in 1883. Dr. Prince calls it "enucleation of the trachoma follicles." It is, however, an *expression*, effected by the opposed thumbs of the operator after eversion of the eyelid. Incidentally Dr. Prince recommends bromide of ethyl as an anæsthetic in short operations, and believes it to be dangerous only when used to produce prolonged anæsthesia.

—Dr. David Prince in this pamphlet describes various means for securing asepsis and antisepsis for the treatment of wounds, and describes an elaborate contrivance of his own invention for securing a room full of pure sterilized air for operations.

—In this paper Dr. Bishop warmly opposes the method of filling the external meatus with a dry antiseptic powder, in the treatment of suppurative otitis media; and he recommends cleansing the meatus with a 1 to 10,000 solution of mercuric chloride, inflating the middle ear, drying the meatus and dusting it with powdered boric acid containing half of one per cent. of mercuric chloride, or with iodoform. The method he proposes is rational, and the objections he raises to the packing method appear to be sound in theory. Other otologists, who have had a different experience from his, may not agree with him as to the dangers of packing the meatus; but if he has found it inexpedient to pack, it goes for a great deal.

—In his second paper Dr. Bishop, after some very judicious remarks in regard to the measures likely to prove useful in preventing the development of threatened mastoid periostitis, describes and advocates operative interference in cases in which inflammation of the periosteum of the mastoid process, or of the process itself has developed. His views may be regarded as somewhat radical by those who have not investigated the subject thoroughly; but we believe them to be entirely sound, and they are certainly justified by his own experience.

—Dr. Bishop's third paper was read before the Section on Otology of the Ninth International Medical Congress. It contains a useful study of the age, sex and occupation of over 5000 patients who came under his care for disease of the ear, and of the climatic conditions which existed when they presented themselves. More than half of the cases (3018) were of chronic non-suppurative inflammation of the middle ear; one-fourth were of suppurative inflammation of the middle ear. More than half the cases were those of persons employed in in-door work. Other points of interest are brought out in the author's table, which, with his reflections upon his observations are a valuable contribution to the study of otology.

—There is much of sensible suggestion in Dr. Gwyn's paper in regard to the care of new-born infants. We think it especially worthy of note that he objects to the plan of stripping the umbilical cord of Wharton's jelly—a plan which we believe is sometimes the occasion of an umbilical hernia, and which is certainly unnatural. We can also heartily endorse his caution in regard to the first bath of an infant, which might well be banished altogether from obstetrical practice or the office of the nurse. Equally judicious, in our opinion, is his objection to frequent bathing of infants. It is hard to convince refined women that their infants need not, and ought not to be bathed every day; but we believe that the daily bath is one of the most prolific causes of disturbances of digestion in infants which are attributed to everything else, and which baffle the care of mothers and the skill of physicians so long as the daily bath is administered.

We cannot dwell longer on this useful paper; but commend its contents to the attention of all who have the welfare of babies at heart. Its merits are not lessened—although its literary quality is somewhat marred—by a number of errors of spelling, which are probably attributable to the proof-reader.

Literary Notes and Queries.

[In this column the Reporter will publish short items of literary interest and questions addressed to this Journal or its readers, and answers to them, in regard to any literary matters: books, authors, places and prices of publications, etc.]

—*La Riforma Medica*, a medical journal formerly published every day at Naples, began in 1888 the fourth year of its existence, and removed to Rome. Each number consists of eight pages, 15x11 inches, six pages being occupied by original and selected articles, reports, etc., and two by advertisements. The subscription price is 20 lire a year for Italy, and 52 lire a year for the United States.

—The *New Yorker Medizinische Presse*, which is the only medical journal in America in the German language, begins its fifth volume in an enlarged size and improved typography. It is an admirable journal, and can be commended not only to German medical men, but also to all others who can read this language. We are glad to note that the editor promises that no "inserts" will be published in the *Presse* after the present advertising contracts expire. The *Presse* is published in large octavo, 48 pages, once a month; subscription price $2.50 a year.

—The *Cosmopolitan* presents an entertaining collection of short stories and papers of more serious character, with an increasing number of illustrations. The number for January contains an article on apparitions, by Richard A. Proctor, which will prove interesting to physicians and especially to those who are engaged in the study of mental phenomena and experiences.

—The first number ot the *Brooklyn Medical Journal*, bearing date of January, 1888, is before us. It is a handsome number, containing 88 octavo pages, and filled with most excellent material. It is a pleasure to welcome it to the ranks of medical journalism and to wish for it the success which we have no doubt it will attain. There is no reason, as its editors state, why so large a city as Brooklyn, with such abundant clinical material and such competent medical men should not have its own special medical journal; and we are glad that the field is entered by one so good as this. *Floreat!*

—The *Clinical Reporter* is a homœopathic journal, published monthly, at St. Louis, by Fowler & Co.; price, $1.00 a year. The first number, for January, 1888, consists of 24 pages, and contains the statement that it "is entitled to a place in the very front rank of homœopathic journals." This modest assertion will probably be questioned by intelligent homœopaths; and honest homœopaths will, no doubt, take some exception to its wholesale advertising and puffing of certain trade-marked medicines which are at the furthest possible remove from homœopathy. The literary quality of this first number is poor, and its inconsistency is astonishing.

Correspondence.

Release from Responsibility.

Editor Med. and Surg. Reporter:

Sir:—Please oblige an old subscriber with an answer to the following question: Can a *legal* instrument be written, which, on being signed by an adult patient with a dislocated or a fractured bone, will relieve a surgeon from responsibility for any unfortunate result which may follow, directly or indirectly, from the injury received or from the treatment which the surgeon thinks best to use in the treatment of the case?

The above question has been asked of several lawyers here, who say that an instrument cannot be made which would relieve a surgeon from responsibility, no matter how the paper was worded. I would be pleased to have your opinion on the question, as I am inclined to think such a paper could be drawn, in order to protect the surgeon from a certain class of patients who are likely to make the surgeon much trouble and expense, so long as the system of jury trial continues and unprincipled lawyers abound. Hoping to hear from you on this subject, I am Yours truly,

Jan. 25, 1888. A Subscriber.

[A patient is entitled to receive from his physician or surgeon intelligent and skilful treatment, and so long as the physician discharges his duty with fidelity, intelligence and skill, he is not responsible for the results, and needs no previous written release from his patient. If a physician or surgeon is unskilful, inattentive, ignorant or negligent, he is legally responsible for the results; and it is against public policy to permit him to be released from such responsibility. A previous written release in such case is no protection, and would be set aside. The opinion of the lawyers to whom our correspondent applied is entirely correct, and there is no way in which a physician or surgeon can escape an unjust prosecution if he happens to treat a person unprincipled enough to try this means of making money.—Editor.]

Pruritus Ani—Burns.

Editor Med. and Surg. Reporter:

Sir:—Allow me to recommend the following prescription for pruritus ani:

℞ Salicylic acid.....30 to 60 grains.
Cosmoline..... 1 ounce.
M. Sig.—Use locally whenever the itching recurs.

The first sensation from this application will be one of heat and moderate smarting, followed in from one to five minutes by a most complete sense of relief and comfort. In even old and and very obstinate cases the itching will not recur for days, and sometimes for weeks. I would respectfully suggest to my fellow readers of the Reporter to try the salicylic ointment before resorting to the actual cautery, as recommended by Mr. Mitchell Banks (see Reporter, January 21, p. 95). I could back up my recommendatory with a very respectable showing of clinical evidence. I was myself a chronic sufferer from this malady for two years, and first used the prescription on my own person.

I have long since discarded the linseed oil and lime water dressing for burns, and instead have tried to teach my patrons how to use the bicarbonate of soda. Antisepsis is just as important in the treatment of burns as of other injuries. Take from five to ten per cent. carbolized water, and bicarbonate of soda a sufficient amount. Moisten the soda to a pasty condition, and spread the carbolized soda paste thickly over the entire burned area with a knife or spatula. Next moisten layers of absorbent cotton, or of old linen or muslin, in the carbolized water, lay them over the paste dressing, and secure them with a light bandage. By this time the pain in the burn will have nearly ceased.

The bandages should be kept constantly moist with a five per cent. solution of carbolic acid in water, for two days. At the

end of this time the dressing may be gently removed and a new one applied, consisting of saturated solution of boric acid with a sufficient quantity of sub-nitrate of bismuth to make into a paste. This should be applied as was done with the soda paste, and allowed to remain untll the burn is well, unless indications of pus secretion should show through the light bandaging. In such a case the dressing may be removed, the burn cleansed, and the dressing re-applied. If this dressing becomes dry and irritates, it is to be moistened with boric acid solution.

Yours truly, G. Law, M.D.

Greeley, Colorado,
January 25, 1888.

Useful Prescriptions.

Editor Med. and Surg. Reporter:

Sir:—I would like to lay before the readers of the Reporter two prescriptions which I have used with much success. They are the same in principle as others which have been published before, but I believe them to possess some advantages over any which I have seen. They are easily prepared and keep well.

No. 1.

Take: Sulphate of strychnia.....4 grains;
Dilute phosphoric acid... 2 fluid ounces;
Fluid extract of cinchona..8 fluid ounces;
Madeira wine.....1 pint;
Simple syrup.....6 fluid ounces.

Dissolve the strychnia in a small quantity of the phosphoric acid in a test-tube, with the aid of heat, and then mix the various ingredients, and filter. The dose is a teaspoonful or two in a little water.

This prescription I have found useful in all cases in which a nerve tonic was indicated. In preparing it, I sometimes substitute alcohol, diluted with 25 per cent. of chloroform water, for the Madeira wine, and glycerine for the simple syrup.

No. 2.

Take: Hot water.....2 pints;
Salicylic acid.....8 ounces;
Acetate of potash.....1 pound;
Tincture of colchicum seeds. 24 fluid ounces;
Glycerine.....1 pint.
Water....enough to make 6 pints.

Dissolve the salicylic acid and acetate of potash in two pints of hot water; the other ingredients are to be then added, and the whole filtered. The dose is from one to four teaspoonfuls every four or six hours.

In chronic muscular rheumatism, I often add the fluid extract of black cohosh (snakeroot) in ten to fifteen drop doses. Both these preparations I keep always in stock, and find them very useful and handy remedies.

Yours truly, A. D. Bundy, M.D.

St. Ansgar, Iowa,
January 24, 1888.

Notes and Comments.

Reminiscences of Ricord.

Hon. Chas. Gayarre, in an address before the New Orleans Medical and Surgical Association (*New Orleans Med. and Surg. Journal,* January, 1888), gives an account of a number of physicians whom he had met in the course of a long life of partial invalidism. From this address we take the following interesting reminiscence of Ricord:

His genial manners were as enticing as his conversational powers, when he chose to exert himself. There was not much difference of age between us. He was born of French parents, in Baltimore, and rapidly rose to celebrity in the land of his ancestors. His capacity for labor was incredible, and his physical strength was equal to any fatigue. At early morn his work began. After numerous visits and after having attended the crowded hospital of which he had the charge, he would return home at 11 o'clock to breakfast, and from 12 to 6 P. M. his reception of patients lasted. At 6 precisely, the door of his office was closed. Those who had not the good fortune to see him had to take their chance on the next day. After dinner he drove rapidly to every part of the vast city where he was needed, and sometimes at 2 o'clock in the morning he was to be met at the masked ball of the Grand Opera as fresh and buoyant as if he had had nothing to do but sleep during the day. On every Sunday he denied himself to the public and went to some solitude in the environs of Paris, where he wrote what he intended to publish. He affected to be a materialist and advocated his thesis with much intellectual vigor and much apparent conviction. As I was opposed to the annihilation of my soul, I always took the opposite side of the question. An incident, however, made me doubt the sincerity of his sentiments on that subject.

As I have already said, the immense saloons of the great physician were always full from noon to six in the afternoon. The patients were admitted in turn to his presence. He was unapproachable during those hours except to suffering humanity. As a proof of his regard he had kindly exempted me from the rule. One day when I had something to communicate to him without delay, I called at the time I knew him to be engaged.

"Pierre," I said to the servant who was in attendance, "carry my card to your master. I must have access to him without being seen by the crowd of invalids who might complain of preference granted to me if I

were admitted before those who preceded me here."

He returned after a few minutes and said: "I will conduct you, according to the doctor's instructions, to his bed-chamber, which can be reached through a secret passage. There you will please to wait until I am permitted to take you to his office."

Ricord, at that time, was a bachelor, and I believe has never married. What was my astonishment, when I entered a very large bedroom, of which the walls, from the high ceilings to the floor, were covered with none but magnificent oil paintings, representing sacred subjects. At the head of the bed was a sculptured oak *prie-dieu*, on which there was a superbly illustrated copy of the Gospels that was lying open. There was a red velvet cushion to kneel on at the foot of the *prie-dieu*, surmounted by a beautifully carved ivory figure of Christ on a gilded cross. After a little while I was led to the presence of the medical philosopher, who habitually seemed to delight in being a cynical unbeliever. Guessing at what had passed in my mind, he said, with a laugh not unmixed, I thought with some embarrassment of manner, "You are surprised, are you not?"

"Certainly," I replied; "who would not? Faith! my first impression was that I had been introduced by mistake into the bed-chamber of the Archbishop of Paris."

"Well! Well! my friend," said he, in a half jocose and half serious tone; "I hear and see so many unclean things during the day that on retiring at night I like, before going to sleep, to refresh my eyes by looking round my room on holy objects."

Several times since, in my social intercourse with Ricord, who never desisted from parading his materialism, I tried to allude to what I considered a singular and secret contradiction of his openly professed doctrine, in order to obtain further light on the subject, but he always glided away from it, and, finally, I had to cease all efforts in that direction, because I saw that it was his wish to have the incident forgotten and unexplained.

Maternal Impressions.

Dr. Hartley Dixon reports, in the *Edin. Med. Journal*, November, 1887, the case of a woman who was travelling by train and had a fall. Her right eye was much bruised, and she suffered severely from it for many days. From the upper part of the left ear a piece of an angular shape was cut out. She was six and a half months pregnant at the time of this accident. In November, 1884, she was safely delivered. The child, when born, had a bruised appearance, extending over the whole lower lid and upper portion of the cheek. The left ear presented the appearance as if an angular piece had been snipped out in the same position as in that of the mother.

Experimental Studies upon the Causation of Typhoid Fever at Iron Mountain, Mich.

Dr. Victor C. Vaughan, and Frederick G. Novy, M.S., of Ann Arbor, Mich., have been investigating the cause of the outbreak of typhoid fever at Iron Mountain, Mich. From an account of their investigations in the *Medical News*, January 28, 1888, we gather that they were unsuccessful in finding any ptomaine in the flasks supplied with meat or milk, which were examined forty-seven and a half hours after they had been inoculated with the Iron Mountain or Lansing water. From a flask of meat preparation which had been inoculated with Iron Mountain water and allowed to stand seven days, however, a syrupy residue was obtained after treatment with suitable reagents. This, when injected into cats, produced fever, retching, anorexia, dilated pupils, and coryza. The symptoms lasted generally only a few hours. One animal seemed to have pain in the abdomen. One cat was killed with chloroform, and redness of the mucous membrane was found, with small ulcerations in the region of Peyer's glands. The authors remark that, if their extract contains the typhoid poison, they would expect it to produce in general the symptoms of the disease; but they would expect these symptoms to be temporary. In 1885, Brieger obtained a ptomaine from a pure culture of Eberth's bacillus, but the symptoms obtained from injecting the latter into animals were a slight flow of saliva, frequency of respiration, dilatation of the pupils, profuse diarrhœa, paralysis, and death within twenty-four to forty-eight hours. The bacilli of Eberth are described as about one-third the size of the red blood-corpuscles of man, and about three times as long as broad; though they may grow to long threads. The short rods have plainly rounded ends and very active movements. They are affected by the aniline colors less than most germs, and are best stained by methylin-blue. Birch-Hirschfeld has recently detected spores by growing the bacillus in stained cultures. Seitz and Wolfhügel have found that it grows abundantly in milk. Hochstetter found the germ in artificial seltzer water a week after its introduction. Seitz found that quinine, kairin, antipyrin, thallin, salicylic acid, and calomel in certain

proportions, arrest the growth of the germ in cultures; but that naphthalin, which seems to be a useful intestinal disinfectant in some diseases, is without effect upon the typhoid bacillus. Upon potato, the typhoid bacillus shows a characteristic but invisible growth. Kraus has declared that the ordinary water bacteria destroy the typhoid bacillus.

A chemical analysis of the Iron Mountain water shows a great excess of chlorine. The wells which supplied the infected water were from six to twenty feet deep. There is no sewer to carry off the filth, but there is a large ditch running through the village, which conveys the water from the mine to a small lake beyond the village. This ditch is used by many as an open sewer, and ice taken from the lake into which it empties supplied the village last summer.

In conclusion, the authors state that there cannot be any doubt that the epidemic at Iron Mountain is one of genuine typhoid fever. The intestinal lesions were observed in one post-mortem. Similar lesions were found in the cat; the specific germ of typhoid fever exists in the water; and the chemical poison, or ptomaine, is formed by the growth of this germ.

The Frequency of Cancer of the Larynx in Different Countries.

M. Mollière, of Lyons, says the *Lancet*, January 14, 1888, thinks that carcinoma of the larynx must be much more common in Germany and Italy than in France and England, for while he himself sees annually some 7000 surgical patients, he has never had a case suitable for extirpation of the larynx. This operation is known to be a very uncommon one in France and in England, while no less than seventy-six cases were mentioned at the Dresden Congress, and 101 operations are referred to in the Italian "Archives of Laryngology."

Enormous Nævus.

R. v. Planner reports, in the *Vierteljahrsschrift f. Dermat. und Syphilis*, 1887, p. 449, the case of a female infant, six months old, who had a nævus larger than a child's head, and including the upper half of the right thigh, the right labium majus, the perineum, and the right buttock.—*Centralblatt f. die med. Wissensch.*, Nov. 19, 1887.

Pasteur Institutes and Hydrophobia.

Dr. Geo. W. Rachel says (*N. Y. med. Presse*, Nov., 1887) that it is a very suspicious circumstance that in all the countries in which a Pasteur Institute exists, the number of cases of rabies reaches an incredible height; while in other countries, particularly in Germany, this increase is very moderate, and affects only those who can actually go to Paris to Pasteur. The opinion that rabies is nothing but a psychical disease, which has been embraced hitherto by only a small minority among physicians, is strongly supported by this fact. Later generations may look upon it as a great, though in truth an unwilling service on the part of Pasteur, that by his leadership in this direction he has contributed very largely toward undermining the belief in rabies and consigning this last remnant of superstitious error to the same limbo of forgetfulness into which sorcery and witchcraft have already fallen.

Treatment of Pruritus Senilis.

For the treatment of this obstinate affection Machiavelli recommends (*Gaz. med. Ital.*) external remedies as most efficacious. As general measures, baths medicated with sulphate of potassium, and the avoidance of all excess in diet. The patient must abstain from scratching, and when a paroxysm of itching comes on, he should dab on the pruriginous spots a one to two per cent. solution of carbolic acid in water. If papules appear and the pruritus is worse at night, cloths soaked with the same solution are to be bound on. An itching scrotum is to be worn in a suspensory bandage enveloped in absorbent cotton. In persistent itching, especially of the female genitals, repeated bathing with the following—

Carbolate of sodium	25	grammes.
Cologne water	75	"
Glycerin	100	"
Water	300	"

M.

will be useful, especially if followed by compresses soaked in the following:

Distilled water	300	grammes.
Alcohol	100	"
Hydrochlorate of cocaine	75	centigrammes.

M.

When the patient cannot resist the impulse to scratch, and does scratch unconsciously at night, the parts are to be painted with:

Ammoniate of mercury	1	gramme
Oxid of zinc	4	"
White vaseline	40	"
Cocaine	25	centigrammes.

M.

—*N. Y. Med. Journal.* Dec. 24, 1887.

Rewards for Service to the Crown Prince.

The *Med. Press and Circular*, Jan. 11, 1888, says: The attending physicians and surgeons of the Crown Prince of Germany have not been neglected by their illustrious patient during the season of "peace and good will toward all men" recently passed. For example, it is reported that Sir Morell Mackenzie has received as a present a valuable case of instruments; Herr Krause, a diamond pin; Herr Schroeter two superb Japanese vases; Herr Bergmann, twenty-four silver table ornaments; and Herr Schmidt, a gold inkstand. Apart from the intrinsic value of the gifts, it is quite possible to conceive that the possessors will treasure them as an earnest proof of the gratitude of the distinguished donor, on whose behalf their best efforts have been lately expended in order to avert distressing symptoms.

How to Clean the Hands.

Dr. P. Fürbringer, of Berlin, has published a pamphlet upon the disinfection of the surgeon's hands and finger-nails. From an abstract of this in the *Med. Press and Circular*, Jan. 11, 1888, we take the following, which the author recommends as the speediest method of cleansing the hands, consistent with security:

1. The nails are to be cleansed dry (scraped or rubbed) from all visible dirt.

2. The hands are to be thoroughly scrubbed with a brush for a minute and a half in hot water and soap, special attention being paid to the edges of the nails.

3. They are then to be washed for one minute in alcohol (not under 80 per cent.), and then, before drying,

4. They are to be put into the disinfecting solution, 2 per cent. sublimate or 2 per cent. carbolic solution, and here to be thoroughly cleansed for another minute.

He claims for this method (1) Certainty of disinfection. (2) Saving of time. (3) Saving of the hands. (4) Smaller expense in the use of the sublimate.

The William F. Jenks Memorial Prize.

The first triennial prize, of two hundred and fifty dollars, under the deed of trust of Mrs. William F. Jenks, will be awarded to the author of the best essay on "The Diagnosis and Treatment of Extra-uterine Pregnancy." The conditions annexed by the founder of this prize are, that the "prize or award must always be for some subject connected with obstetrics, or the diseases of women, or the diseases of children;" and that "the trustees, under this deed for the time being, can in their discretion publish the successful essay, or any paper written upon any subject for which they may offer a reward, provided the income in their hands may in their judgment be sufficient for that purpose, and the essay or paper be considered by them worthy of publication. If published, the distribution of said essay shall be entirely under the control of said trustees. In case they do not publish the said essay or paper, it shall be the property of the College of Physicians of Philadelphia." The prize is open for competition to the whole world, but the essay must be the production of a single person.

The essay, which must be written in the English language, or, if in foreign language, accompanied by an English translation, should be sent to the College of Physicians of Philadelphia, Pennsylvania, U. S. A., addressed to Ellwood Wilson, M.D., Chairman of the William F. Jenks Prize Committee, before January 1, 1889. Each essay must be distinguished by a motto, and accompanied by a sealed envelope bearing the same motto and containing the name and address of the writer. No envelope will be opened except that which accompanies the successful essay. The committee will return the unsuccessful essays if reclaimed by their respective writers, or their agents, within one year. The committee reserves the right to make no award if no essay submitted is considered worthy of the prize.

Hæmostatic Pills.

Huchard recommends (*Revue Internationale aes Sciences Médicales*):

> Aqueous extract of ergot,
> Sulphate of quinine, of each 1 drachm.
>
> Mix. Divide into 40 pills. Dose, six to ten pills a day for hæmoptysis, metrorrhagia, etc.

The Duration of Pregnancy.

In an inaugural dissertation bearing the title, "Is There a First Month of Pregnancy?" (Berlin, 1887), Sachs has endeavored to solve the question as to the time of conception in a new way. As is well known, opinions have differed heretofore as to whether impregnation occurs with the ovum of the last menstrual period or with that of the first period which is missed; or, as Leopold has suggested, from an intercurrent ovulation. The new theory, founded by Sigismund, Löwenhardt and Reichert, that it is the ovum of the first missed period which

is impregnated, though not generally accepted as correct, is nevertheless claimed by its original defender as being of universal application. If this were true, as His has already pointed out, the position of the day when the productive coitus took place would have no effect on the duration of pregnancy, since the latter begins with the first absent menstruation. Sachs has collated from the literature of this subject all cases in which a single intercourse led to pregnancy—in other words, in which the period of conception could be definitely fixed. From these he has arranged a series, according to the relation of this period to the time of the last menstruation, and has compared in this series the duration of pregnancy in the different cases, or the time elapsing between the first days of the last menstruation and the date of confinement. From the comparison it appears that in those cases in which the period of conception was near the last menstruation, the average duration of pregnancy was 277 days, while in the cases in which it was near the first missed menstruation, the duration was 293 days. Since such a difference can hardly be accidental, Sachs looks on it as proving that the later the period of conception the longer is the duration of pregnancy.

Strangulated Femoral Hernia, with Entire Absence of Local Pain.

In the *Lancet*, January 14, 1888, Mr. O. B. Shelswell reports the case of a woman, 49 years old, who applied to him on November 20, suffering from very severe abdominal pain especially on the left side and around and above the umbilicus; vomiting and constipation were also present. These symptoms had commenced on the previous day. It was learned, on inquiry, that purgatives had been employed, but with no effect on the constipation. There was a lump in the right groin, to which the patient had given no heed, as it was not painful. It was of irregular shape and felt very hard, except at the lower part; no impulse was felt on coughing. The diagnosis of hernia was aided by the history that the tumor had appeared suddenly some weeks previously. Taxis was tried, and though it did not produce pain, was without success; and on the next day, as the nausea had increased and the vomit was very offensive, Mr. Shelswell operated. The result was entirely successful. This case is interesting and instructive, as illustrating the fact that strangulated hernia may exist with entire absence of local pain.

Treatment of Warts by Internal Administration of Arsenic.

Mr. B. G. Pullin, in a communication to the *Bristol Medico-Chirurgical Journal*, December, 1887, says that during the last two years many cases of warts on the hands of children have come under his notice for treatment. He reports three cases, which, if they are to be credited, certainly show remarkable efficacy on the part of arsenic. The first case was that of a young woman of 17, who had innumerable warts on her hands, which had grown with great rapidity. Some of the largest of these had attained their growth within a week or ten days; the whole skin of the hands seemed to be filled with small growths, some not visible, but easily distinguishable to the touch. Nitric acid was applied to about one-half dozen of the largest, and she was given three minims of liquor arsenicalis, and returned in a week without the vestige of a wart. In the second case, that of a boy 8 years old, no local treatment was used, and all the warts but one had disappeared in two weeks, under two minims of the liquor arsenicalis. The remaining one was removed with the finger. The third case is similar to the second.

Philadelphia Clinical Society.

The Philadelphia Clinical Socity at its annual meeting, January 27, 1888, elected the following officers: *President*, Dr. Mary E. Allen; *First Vice-President*, Dr. Clara Marshall; *Second Vice-President*, Dr. Marie B. Werner; *Treasurer*, Dr. L. Brener Hall; *Rocording Secretary*, Dr. Mary Willits; *Reporting Secretary*, Dr. Mary Willits; *Corresponding Secretary*, Dr. Emma E. Musson; *Councillors*, Dr. Amy S. Barton, Dr. I. G. Heilman, Dr. A. Victoria Scott, Dr. Edward E. Montgomery, Dr. James B. Walker.

Northern Medical Association of Philadelphia.

At the last annual meeting of the Northern Medical Association, of Philadelphia, the following officers were elected for the year 1888: *President*, George W. Vogler, M.D.; *Vice-President*, Joseph S. Gibb, M.D.; *Recording Secretary*, Daniel Longaker, M.D.; *Reporting Secretary*, Louis J. Lautenbach; *Treasurer*, Charles P. Noble, M.D.; *Censors*, J. P. Stritmatter, M.D., to serve four years; L. Brener Hall, M.D., to serve five years.

Iodoform in Surgical Practice.

A "General Practitioner" writes to the *Peoria Medical Monthly* that he has employed iodoform with great freedom in many cases of severe injury, with extensive laceration of tissue, and the wounds have proceeded from first to last dressing without any other application whatever. He is heartily in favor of the dry dressing of wounds, and has found no agent which has so satisfactorily served this purpose as iodoform.

He says he has had four cases in which the use of iodoform has produced an irritation of the skin, which began by the formation of small, irregular elevations of the epidermis around the wound, and was accompanied by itching. In a day or two these elevations passed into vesicles containing a clear, thin, watery fluid; and, breaking down soon after their formation, this fluid kept the parts constantly wet. If the iodoform dressing be discontinued at the first appearance of the rash, and a simple soothing ointment, such as the oxide of zinc, be applied, the duration of the skin trouble is of brief duration. Care must be taken, however, to prevent the extension of the eruption to contiguous parts, also to the face and other parts of the body. He thinks the trouble is spread through the fluid contained in the vesicles, for when their watery contents flow upon adjacent parts, a fresh crop is apt to soon appear. It has in one case been transferred to the face by carelessness of the patient in not washing his hands, and in that case it spread rapidly, accompanied by great swelling and some pain. For a short time it had the appearance of erysipelas, and occasioned him no little uneasiness, but it was soon relieved by a free application of the oxide of zinc ointment. In another instance the nurse became careless about cleansing his own hands after dressing the affected part, and the rash soon appeared upon his hands, and followed its usual course.

He has only seen one case in which any constitutional affects followed the use of iodoform, and in this one the drug was used, suspended in glycerine, as an injection into the cavity of an old abscess in the inguinal region. Half a drachm of iodoform in glycerine was injected, after washing out the sac with hydrogen peroxide. After the fourth injection, the patient complained of trouble with his kidneys, scanty urine and pain in the back over the kidneys. He also complained of headache, loss of appetite, and a general malaise. The taste of the drug was quite unpleasant. A discontinuance of its use was promptly followed by an amelioration of all unpleasant symptoms. To determine the cause of the symptoms, he returned to the use of the drug in the same manner, and the same symptoms returned and continued during its use.

The author has frequently used iodoform as a local application in the treatment of erysipelas, and has found it to be better than any other application which he has used. He suspends one or two drachms of the drug in two ounces of glycerine and orders it applied frequently to the affected areas.

A Druggist Unjustly Accused.

The *Chemist and Druggist*, January 7, 1888, cites from the *Pharmaceutische Post* the following extraordinary story: In the year 1883 a chemist's assistant, named Martins, was tried at Inowrazlaw for the manslaughter of a child to whom liquid carbolic acid had been administered by mistake for some other drug, ordered at the same time by the mother of the victim. Martins had dispensed both recipes. He was found guilty and sentenced to three months' imprisonment. However, he committed suicide by drowning before the sentence was carried out. Sometime afterwards the mother of the child confessed that she had herself made the mistake of administering the carbolic acid to her infant, and then, fearing detection and punishment, had altered the labels of the two bottles so as throw the blame upon the chemist.

Effect of High License.

St. Paul *Pioneer-Press*, January 16, states that high license in Minnesota is having a very salutary effect in diminishing the amount of drinking and drunkenness in that state. It asserts that in Minnesota there are 1600 fewer saloons than a year ago; in Ohio, 2600 saloons have been closed under the tax law; in Illinois, 4000 saloons have gone. In Missouri the reduction is one-fifth. High license has cut off the very worst form of drinking. It has been impossible, hitherto, to start any new enterprise in St. Paul involving the employment of a large number of men in one building without the establishment of a saloon at the very doors. Anxious as proprietors have been to keep temptation out of the way of their men, somebody would sell or lease a lot, up would go a rough shanty, and every workingman was compelled to pass its doors on his way to and fro. In every little band of men leaving their labor there will be one or two who want to drink,

and a majority who drink occasionally, but are not bound by the habit. These latter might go on their way unharmed if there were no temptation. But the saloon is there, somebody proposes that they go in and have a drink, nobody wants to resist too earnestly, several "stand treat" according to the noble American habit, the dice are brought out, and the workingmen go away at last poorer in pocket and unsteadier in legs. This is the sort of saloon that high license wipes out. It is the worst of all saloons, because it does not minister to appetite but *creates* it.

"One further consideration," the *Pioneer-Press* says, "should be borne in mind by honest temperance men. We have never claimed that high license was a perfect panacea for all ills of the liquor traffic. We do not claim it now. We say unhesitatingly that it is the best remedy tried or known for cities. So far there are but two practical methods of dealing with the problem—prohibition and high license. On the ground of diminished drinking alone, high license is immeasurably superior in cities, while in other respects prohibition has nothing whatever to offer."

Kephir as a Food for Infants.

Kephir is the product of a special fermentation of cow's or goat's milk, analogous to koumiss. In the *Cincinnati Lancet-Clinic*, January 21, 1888, Dr. H. L. Taylor reports success from its use in the wasting diseases of children. He quotes the following conclusions as to the value of kephir from a communication by Theodoroff to the Medical Society of Würzburg, in 1886:

1. During its use the quantity of urine is increased, but only in proportion to the quantity of fluid consumed.
2. The specific gravity of the urine sinks, and also the weight of the solid matter.
3. Nitrogenous changes are checked.
4. Digestion is strengthened and stimulated in even the worst forms of dyspepsia, and the nutrition of the body is improved.
5. The gain in body weight is rapid and enormous.
6. The number of red blood corpuscles increases.

And, lastly, kephir is therefore to be regarded as one of the most valuable aids known in building up or retaining the power of the body in all conditions of great general debility.

The experiments in infant feeding at the Home are to be continued, and a second and more mature report will be made in regard to the matter.

Value of a Scrap-Book.

A man very eminent in scientific journalism was once asked by the writer what he regarded as the most valuable book of reference in his library on a certain subject. "This," he answered, and picked up a well-filled and well-indexed scrap-book, the contents of which had been accumulated by years of careful attention to the columns of the periodical literature on the subject mentioned. A trial of his plan has since proven the truth of his words. Keep files of your journals by all means, but keep a scrap-book as well. You will find that it will pay you.—*National Druggist*, Jan. 15, 1888.

Antipyrin in Hæmoptysis.

In the *Meditzinskoïe Obozreniĕ*, No. 5, 1887, p. 520, Dr. M. Byvalkevitch, at the Vilna Military Hospital, states that antipyrin is an excellent remedy for pulmonary hemorrhage of every kind. This statement is based on ten cases of hæmoptysis in patients suffering from phthisis, bronchiectasis, cardiac disease, and traumatic injury of the chest. The following mixture was invariably employed by Dr. Byvalkevitch:

℞ Antipyrini.....3ss
Aq. destil.....f℥iv
Essentiæ menthæ pip.....gtt. xv
Mix. Dose—One tablespoonful every two or three hours.

In none of the cases were more than two doses of the mixture required to completely arrest hæmoptysis, even when the daily loss of blood amounted to two fluid pounds. In some of the patients, ordinary hæmostatics, such as ergot, ergotin, digitalis, atropine, and Haller's elixir, had been previously tried without effect.—*Brit. Med. Journal*, Dec. 24, 1887.

For Irritable Bladder.

Dr. W. P. Chunn writes to the *Maryland Medical Journal*, January 28, 1888, that the following prescription has been found to allay incessant desire to urinate and irritable bladder, when due to phosphatic deposits in the urine:

℞ Acidi benzoici.....3ij
Boracis.....3iij
Aquæ.....℥xij
M. Sig.—Tablespoonful three times a day.

This mixture has, upon two occasions, acted so efficiently in what was thought to be cystitis that cystotomy was dispensed with.

NEWS.

—Dr. Thomas L. Hazzard has withdrawn from the editorial staff of the *Pittsburgh Med. Review.*

—Dr. Paul Gibier has been sent by the French government to Cuba to study the bacteriology of yellow fever.

—Dr. W. T. Councilman, who is Associate in Pathology in the Johns Hopkins University, Baltimore, has been elected to the chair of Anatomy in the same institution.

—Dr. James Hendrie Lloyd has been elected Neurologist to the Philadelphia Hospital, in place of Dr. Roberts Bartholow, resigned.

—A case of leprosy is said to have developed in Marysville, Cal. The victim is a colored barber, for twenty years a resident of that city.

—Professor Tito Vanzetti, of Padua, one of the most distinguished of Italian surgeons, died January 6, 1888, aged 78 years. He was professor of clinical surgery at the University of Padua.

—A private hospital has been established by Dr. G. Bretton Massey, at 3240 Chestnut street, Philadelphia, for the treatment of cases of nervous diseases. Patients admitted to this hospital may be under the care of the physician by whom they are sent.

—It is reported that an epidemic of pneumonia began in the neighborhood of Montpelier, Ind., about a month ago, which has caused many deaths, and many are now low with the disease. Black measles have also broken out in Keystone, a small village three miles north of Montpelier.

—Dr. J. K. Bartlett, who practiced for many years in Milwaukee, Wis., has removed from that city, and taken up his residence permanently in Berkeley, Cal. The change of residence at this period of his life was caused by the hope of benefitting the health of his family.

—If certain announcements recently made in the daily press of the country be true, the aluminium problem is rapidly nearing solution, and before the close of the year of 1888 we shall see that metal almost as cheap as German silver or the finer brasses. At 25 cents per ounce (the price at which it is now promised us), and with silver at $1.10 per ounce, aluminium is, for use in the arts and manufactures, practically nearly eighteen times cheaper than silver.

—Dr. R. A. McLain, of the Department of Animal Industry at Washington, who, with his deputies, has been engaged for the past year in stamping out pleuro-pneumonia among the cattle in Westchester county, New York, went to New Rochelle, January 19, and slaughtered about seventy registered cows on the farm of Frank J. Cazanes, who has a milk-route in the village. In and about the county several hundred head of cattle have been slaughtered to prevent the spread of the pest.

—The New York Post-Graduate School and Hospital held its annual meeting on January 18, and elected officers for the year. The treasurer's report showed the financial condition of the school to be more flourishing than ever before, the number of matriculates having this year increased over eighty-seven per cent. The hospital department has increased its space by the addition of a woman's ward, and also one for men. It is hoped that the babies' ward will soon be endowed.

—Dr. Cazeneuve, professor of chemistry and toxicology in the Lyons Faculty of Medicine and Pharmacy, met with a painful accident a few days ago. While working in his laboratory a test tube burst and several pieces of the broken glass wounded him in the face. The cornea of the right eye was perforated by one fragment, which was extracted from the anterior chamber after an iridectomy was performed. The lens has become involved and is opaque and swollen. It is feared that the eye will have to be enucleated.

—The president of the English Society for the Study of Inebriety, Dr. Norman Kerr, began a course of medical lectures on "The Disease of Inebriety and its Treatment," in the hall of the London Medical Society, on Jan. 12, 1888.

Dr. T. D. Crothers, of Hartford, Conn., delivered two lectures on the same topic, before the Albany Medical College, Jan. 24 and 25, 1888. These are the first medical lectures on inebriety, and the first efforts to present this subject in connected detail by medical men, from a purely scientific standpoint.

—The medical report on the condition of affairs at the Quarantine Station in New York Harbor, submitted by Mayor Hewitt to Governor Hill, fully vindicates the committee of Philadelphia physicians whose sharp criticism of the methods in vogue at that

place first drew attention to its condition. It shows that those physicians, far from being alarmists, did a public service worthy of the praise and thanks of New York, and of the nation. An epidemic getting a foothold in New York would cause almost incalculable damage to that city, not to speak of the personal misery and loss of life which could scarcely be confined to that port alone. Compared to that loss, the cost of properly fitting up the Quarantine Station, and of employing honest and fully competent officers to manage it, would be trifling indeed. It was a priceless service to New York to bring her authorities face to face with the actual condition of Quarantine.

—When it is a question of nerves, the power of imagination is supposed to be stronger in women than in men, but this was not shown in a recent hospital experiment. Dr. Durand, wishing to test the practical effect of mind disease, gave a hundred patients a dose of sweetened water. Fifteen minutes after, entering apparently in great excitement, he announced that he had, by mistake, given a powerful emetic, and preparations must be made accordingly. Eighty out of the hundred patients became thoroughly ill, and exhibited the usual result of an emetic; twenty were unaffected. The curious part of it is that, with very few exceptions, the eighty "emeticised" subjects were men, while the strong-nerved few, who were not to be caught with chaff, were women.

—At the last meeting of the botanical section of the Biological Society in Washington, an interesting paper was read by Professor F. H. Knowlton on the obstruction of sewers by roots of trees. A map of fibrous roots was exhibited, which was taken from an obstructed sewer in that city by Mr. Burns, of the Geological Survey. The distance to which roots sometimes penetrate, Professor Knowlton said, is remarkable. The roots of clover have been found nine feet below the surface and those of parsnips fourteen feet. Roots of the elm have been known to obstruct an acqueduct 300 feet distant, and in one instance a tile drain was filled, which was 450 feet away. Some roots absorb moisture only from free or liquid water, while others will die if placed in such water, and can obtain their supply only from hydroscopic water, or that which adheres to the particles of ordinary soil. This fact explains why the roots of certain trees are troublesome in drains and of others not.

HUMOR.

A MEDICAL STUDENT, at his examination, was asked: "If you were called to a man who had fallen into a well forty feet deep and struck his head against a stone at the bottom, what would you do?" "I would let him lie," he answered, "and have the well filled up."

"I AM SORRY," said a clergyman, "that your wife has such a heavy burden to bear." "Yes, she does—that's so," acquiesced his parishoner. "She's laid there flat on her back this seven years. Seems as if she'd get altogether worn out. I do wish she'd get well—or something."

"I WANT a surgeon at once," he said, as he hastily entered a hospital; "I've just shot three of my fingers off!" "I'm sorry, my friend," replied the superintendent, "but you'll have to grin and bear it for awhile. The surgeons are all over to the toboggan slide."—*Texas Siftings.*

A LITTLE BOY came to a druggist with a prescription for castor-oil. The druggist put it up, and the boy offered ten cents in payment. "That is not enough money," said the druggist. "There's fifteen cents' worth in that bottle." The boy thought awhile, and then answered: "I'll tell you. You drink five cents' worth, and then the money will be enough."—*Fliegende Blätter.*

A YOUNG DOCTOR, who had his eye on a banker's daughter, thought to win the favor of the father, who was his patient, by sending him a very low bill. Soon afterwards he asked the father for the daughter's hand. To his surprise the father refused, and being pressed for his reason for refusing, told the young man he could not trust his daughter to a man who had such a poor head for accounts.—*Fliegende Blätter.*

IN A LETTER to his doctor, a Liverpool man wrote: "If vaxinnation was to Prevent a person from getting this decease, and can convince me of it, You would have got my two sisters vaxinnated before this time. But I don't believe in this merracul, and have no confidence in it. If Providence whiches to lay a Person Sick in bed, no matter what decease it is—I trust in him and have confidence in him that he can Relieve them and also Prevent the decease."

A MAINE DOCTOR was called upon by a man who desired to get a prescription for whiskey. "For what purpose?" asked the doctor. "Mechanical," said the man with a countenance honest enough to look any

Judge in the country out of countenance. After writing the prescription and handing it to the man the doctor said, "For what kind of mechanical purposes do you intend to use the whiskey?" "Sawing wood. Good day, sir," was the reply.

ANOTHER LONG-FELT WANT.—Caller—Any back numbers of your magazine?

Health Journal Editor—Yes, sir. Which number do you wish?

"I do not know the date, but I saw a line in a paper to the effect that it had an article entitled 'How to lie when asleep.'"

"I know which number you want. Having trouble at night, eh?"

"I should say so. My wife says I talk in my sleep and I know from the way she acts that I tell the truth."

THE GIRARD HOUSE MEDICINE-CUP.—In the Girard House, a large hotel of Philadelphia, there is a white marble ice-water fountain, with a silver cup dangling from a chain. So many people have been taking pills, cod-liver oil, cough mixtures, and other decoctions with the help of the silver cup, that the cup got to taste like all the medicines that were mixed in it, and it smelt like a drug-store. Recently another silver cup was chained to the fountain; and over the old one hung a sign which read, "This is the medicine-cup."

THE HORSE BLEW FIRST.—A veterinary student, having been sent to administer a dose to a sick horse, was asked by his preceptor what success he met with. "None at all," he replied: "the horse bit me." The preceptor then explained that he should have put the powder into a medicine-tube, and, placing one end in the side of the horse's mouth, blow it into his throat; whereupon the student proceeded to act upon the suggestion. Returning again, he was asked what success he had this time. "None at all," he replied: "the horse blew first!"

"DOCTOR" IS A very promiscuous title in America. The preacher is a "doctor." The school principal is a "doctor." The family physician is a "doctor." The veterinary surgeon is a "doctor." The dentist is a "doctor." The manufacturer of patent medicines is a "doctor." The remover of pedal excrescences "without pain" is a "doctor." And so on. There are almost as many "doctors" in the South. But this is a free country. In Germany, under the despotism of a monarchy, this freedom is not allowed. An American dentist has just been fined in Berlin for putting "Doctor" on his cards.

OBITUARY.

ASA GRAY.

Professor Asa Gray, the veteran botanist, whose books on botany have done so much for the study of botany in the United States, died Jan. 31, 1888. He was born in Paris, Oneida County, N. Y., Nov. 18, 1810. He was educated at the Clinton Grammar School and the Fairfield Academy, and studied medicine at the College of Physicians and Surgeons of the Western District of New York, where he was graduated in 1831. He soon turned his attention to the study of botany with Dr. John Torrey. Being a clear and entertaining writer on his favorite branch, he soon became widely known, and, after declining the chair of botany in the University of Michigan, accepted the Fisher Professorship of Natural History at Harvard, a position which he held frnm 1843 to 1873, when he retired from the active duties of the office, though still retaining his connection with the school.

The honors Professor Gray received from colleges and learned societies were many; but his most enduring fame is as the author of the simple little books which tell "How Plants Grow" and "How Plants Behave," and which have planted a crop of botanists in villages and hamlets all over his native land.

Official List of Changes in the Stations and Duties of Officers serving in the Medical Department, U. S. Army, from Jan. 29, 1888, to Feb. 4, 1888:

Promotions.

First-Lieutenant W. W. Fisher, Assistant Surgeon, ordered to Presidio of San Francisco, Cal. S. O. 25, A. G. O., Jan. 31, 1888.

Lieutenant-Colonel Charles Page, Surgeon, to be Assistant Surgeon-General, with rank of Colonel, Nov. 17, 1887.

Major James C. McKee, Surgeon, to be Surgeon, with rank of Lieutenant-Colonel, Nov. 17, 1887.

Capt. Alfred C. Girard, Assistant Surgeon, to be Surgeon, with rank of Major, Nov. 17, 1887.

First-Lieutenant H. I. Raymond, Assistant Surgeon, ordered to Fort Bidwell, Cal.

Official List of Changes of Stations and Duties of Medical Officers of the U. S. Marine Hospital Service, for the week ended Feb. 4, 1888:

D. A. Carmichael, Passed Assistant Surgeon, detailed as Attending Surgeon and Acting Chief Clerk, Supervising Surgeon-General's Office, Feb. 2, 1888.

F. M. Urquhart, Passed Assistant Surgeon, granted leave of absence for twenty days on account of sickness, Feb. 3, 1888.

L. L. Williams, Assistant Surgeon, ordered to examination for promotion, Feb. 2, 1888.

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Clinical Lecture.

PULMONARY CONSUMPTION AS TREATED IN THE PHILADELPHIA POLYCLINIC.

BY THOMAS J. MAYS, M.D.,

PROFESSOR OF DISEASES OF THE CHEST IN THE PHILADELPHIA POLYCLINIC.

If it is once properly understood that, in the vast majority of cases, pulmonary consumption is a local disease, the nature of which is a low catarrhal inflammation of the alveolar spaces resulting from a want of physiological activity in the affected part, the treatment of this disease will become comparatively simplified. Strange to say, however, everything which is known to be capable of producing morbid phenomena in the human body has, one time or other, been held accountable for the causation of pulmonary phthisis; and it is needless to tell you that its treatment varied accordingly. Let us premise our remarks, therefore, by saying that it is a disease with an intense partiality for the apex of either lung; and the question which most naturally suggests itself is, why the apex is so susceptible to; and why the middle and lower portions of the lung surfaces are so free from it? Is this the result of chance, or is it a law with antecedents as plain as the phenomenon is regular? A correct solution of this important question will go a great way towards defining the true origin of this disease. While not at all wishing to be understood as offering an all-sufficient explanation of this difficulty, we are quite justified in holding that one of the most potent and direct causes for such a state of things lies in the manner in which the bronchial tubes enter and are arranged throughout the lungs. These structures conduct the air principally in a downward direction towards the base of the lungs—hence the lowest parts of the lungs expand first, then the middle, and, finally, towards the very end of inspiration the apices expand, if at all. It is our firm belief, deduced from many observations, that in most persons who —like clerks, telegraph-operators, tailors, shoemakers, etc.—lead a sedentary life, and who maintain a stooped position of their chests and shoulders, the apices never become fully inflated. Another reason why the lower parts of our lungs are inflated more than the apices is because we possess nearly one-fourth more lung surface than necessary to carry on the process of respiration; and, therefore, that part of the respiratory surface which is filled with the greatest facility, viz., the base, performs the work of the whole. Therefore both the structure and the function of our lungs conspire to diminish the activity of the apices and enhance that of the bases. We have already stated, that the chief factor in the production of pulmonary consumption is a physiological inactivity of the lung apex; and if this proposition is true, then it should follow that those persons in whom the apices are least developed should be most liable to this disease, and *vice versa.*

Not long ago we made an investigation into the nature of this problem,[1] and found that the abdominal was the original type of respiration among both sexes; that the costal type of the female developed through the influence of abdominal constriction produced by clothing; that when the female falls a victim to consumption, her costal movements are markedly diminished; and that the female is less liable to consumption than the male in

[1] An experimental inquiry into the chest movements of the Indian female.—*Therapeutic Gazette*, May, 1887.

civilized life. It can be furthermore said that, according to Waldenburg, the vital lung capacity in persons who lead a sedentary life—such as professional men, students, clerks, etc.—is smaller than those who follow an active calling—like sailors, recruits, etc.—and it is a well-known fact that the latter class is much less susceptible to this disease than the former. And, moreover, our American Indians, who are not confined on reservations, and who are free to obey their roaming instincts, are almost entirely exempt from pulmonary consumption, presumably because of the greater lung capacity which their active life entails on them.

All these facts tend to confirm the correctness of our fundamental proposition, at least this far, that increased lung capacity decreases the liability of consumption. We think, however, when this fact is coupled with the other fact, that the civilized female possesses a much smaller lung capacity than the male, and is still less liable to the disease than the male, it is quite obvious that it is not a large chest capacity, but a well developed apex capacity which insures immunity from the disease. Barring her greater apex capacity, there is no reason, so far as we are able to discern, why the female should be more exempt from consumption than the male. Indeed, everything, both in herself and in her surroundings, tends to increase her liability in this direction. She is the weaker of the two; she undergoes the enervating processes of gestation and of lactation; she leads a sedentary and inactive life; she is occupied within doors during the greatest part of her lifetime, and is therefore constantly exposed to causes which are known to produce the disease, and most of which make the male notoriously liable if he is exposed to them.

In the next place it is important to trace the pathological relation between apex inactivity and pulmonary consumption; or, in other words, we must ascertain how such a want in development prepares the apex for the onset of this disease. You are all aware that if any organ, like a muscle, for example, does not receive adequate physical exercise, it diminishes in size; its muscular elements and connective tissue framework shrink in consequence. Precisely the same thing may happen when any part of a lung is deprived of its needed exercise — that is, when it is not expanded as fully as it ought to be during the act of inspiration—the air cells begin to shrink and collapse. The shrinkage is due to a contraction of the connective tissue around the air-cells, and the small bronchial tubes, and when sufficiently pronounced it constricts the blood-vessels and interferes with the free circulation of the blood in that part of the lung, and congestion and a low state of catarrhal inflammation follow as a consequence. This whole condition is analogous to that which occurs in the acquired form of atelectasy, and we would especially commend to you the remarks of Prof. Rindfleisch on the subject Atelectasia, in his well-known work on Pathological Histology. In tracing this state of things farther, we find that the epithelial elements multiply and accumulate in the alveoli and produce what is known as infiltration. In this way one alveolus fills up after another, until a whole group, or a cluster of them, is involved. Such an accumulation of catarrhal products exerts a decided pressure on the surrounding pulmonary and bronchial capillaries, and the blood-supply and nourishment are gradually diminished and finally cut off from these infiltrated areas, which, in due course of time, become more or less isolated and circumscribed masses, which are prone to undergo a slow process of cheesy degeneration, if the morbid process continues.

Pathologically then we have to deal here with a local infiltration of, or an accumulation of catarrhal epithelium in the air cells, brought on by physiological inactivity of the affected area, which area is in the great majority of cases confined to either apex. Now, what is to be done in a therapeutic way? Clearly, there are here two very important indications. The first is to combat the local infiltration, and the second is to annihilate its cause. This is the method which has been pursued for some time in the hospital of this institution.

In regard to the first indication, we would say that we have here an inflammatory deposit differing, in principle, in no wise from a similar deposit in any other part of the body, and the dictates of common sense point out that that which is useful in the one condition is also useful in the other. We all know the inestimable value of counter irritation, and of passive motion in producing resorption of chronic inflammatory deposits in joints, muscular tissues, etc., as well as in the external surfaces; and in consonance with this view we apply hot flax-seed meal poultices, every day from morning until night, for a period of three or more weeks. In connection with the poultice we apply friction, iodine, etc. We are certain, from quite an extended experience, that these measures produce a powerful impression on the infiltration in question, and that they facilitate

resorption more markedly than any other means at our command.

In addition to the poultices, we use local or general massage, once or twice a day, as well as electricity. In these cases of constitutional lethargy these adjuvants have the happy effect of arousing the local and general cell activity, and are usually followed by an increased appetite. In connection with all these external applications—poultices, massage and electricity—we advise our patients to take plenty of fluid food, such as milk, etc. This should not be given to the extent of satiation, but at regular intervals—say half a glass or a teacupful every hour.

So much then for the principal means which we believe have the power of dispersing the infiltrated catarrhal products of the lung; and what can be done in the direction of counteracting the source of the disease? From what has already been said, it must be quite evident to you that any measure which improves the air capacity of the apices will accomplish the end in view. Among the most important measures which fulfil this indication directly are voluntary and forced breathing. The former should be practiced by taking deep and long inspirations at intervals of two hours or oftener throughout the whole day. The inspired air should be retained as long as it conveniently can be in order to give the fullest possible expansion to the whole lung surface. The latter mode of breathing consists in inhaling compressed and exhaling into rarified air, or the reverse. This method is the most important lung expander of all. It should be begun gradually—say twice a day for a week or two, then three times for one week longer, then four times, and finally allow the patient to spend most of his time in the use of this apparatus. The great difficulty here is the limited time which the compressed air is generally employed. We are convinced that the best results follow when its use is protracted.

Physical exercise is an important indirect method by which the lungs are expanded. Under these conditions more oxygen is consumed by the muscles of the body than during rest; hence more blood flows through the lungs in a given time, and a larger lung-surface is thrown into activity. Those parts of our lungs which are but rarely or never called into use now are thrown into a state of healthy expansion, and it is in this way that our whole respiratory apparatus is made to approach that condition which gives the savage, and those who pursue an active life, that freedom from consumption which we know is so common among them.

In carrying out this method of treatment, the following points should be borne in mind: first, no exercise should be carried to the extent of decided fatigue; second, whenever possible, the body and head should be erect, the shoulders thrown back, and the lungs thoroughly filled with each breath; and, third, sufficient food must be taken during the intervals. Among the most important measures to increase the lung capacity is that of pulmonary gymnastics, which should be carried out in accordance with the following directions: The arms, being used as levers, are brought as far backwards as possible, and on a level with the shoulders, during each inspiration, and brought together in front on the same level during each expiration. Another way is to bring the hands together above the head while inspiring, and gradually bring them down alongside the chest while expiring. When a deep inspiration is taken in accordance with either plan and held until the arms have gradually moved forwards or downwards, and even longer, the process of chest expansion is materially enhanced. All these movements may be facilitated by using dumb-bells or chest-weights, etc.

This, in connection with stimulant medicines and nutritious food, has been the general line of treatment pursued, both at the hospital here and in our private practice, for some time; and we commend it to your consideration, in the full belief that you will not be disappointed in its results.

—Two sons of Dr. T. A. West, recently elected City Physician of Knoxville, Tenn., and a third man, named Goodman, attacked Mr. James F. Rule, city editor of a local paper, on Sunday, January 29, as he was entering a church. The attack was made on account of a communication reflecting upon their father, which appeared in the Knoxville *Journal*. Pistols and knives were used, and one of the sons was fatally wounded. The Philadelphia *Ledger*, January 30, 1888, says that the circumstance which called out the newspaper article was the election, on Saturday, of Dr. T. A. West to be City Physician by the City Council. West is not a graduate of a medical college, and the Council had repealed an ordinance for the purpose of making him eligible. This act aroused the indignation of the regular physicians of the city and was denounced by the medical society. The article was written by a physician and contained very severe reflections upon Dr. West and the City Council.

COMMUNICATIONS.

PRIMARY UNION OF THE AXILLA AFTER EXSECTION OF ITS CONTENTS: ILLUSTRATED BY THREE CASES.

BY J. S. WIGHT, M.D.,

PROFESSOR OF OPERATIVE AND CLINICAL SURGERY AT THE LONG ISLAND COLLEGE HOSPITAL.

The question of primary union of the axilla, after removal of its contents, has been one of interest to me for years. Under the ordinary methods of bringing the parts together, I have always failed to bring about such a desirable result. After studying the question from many points of view, I thought of the following plan of bringing the wound surfaces in more complete apposition: A long, curved needle is armed with an aseptic silk suture. The needle is held by a strong pair of needle forceps. The point of the needle is inserted about one-half inch from the edge of the lower posterior flap, and carried under the entire bottom of the wound of operation, so that it will come out of the upper, anterior flap, also about one-half inch from its edge. The suture is completely buried in the tissues, so that it can nowhere be seen. From the lower anterior angle of the wound, going upward and backward, I insert five or six of these long, deep sutures. In some instances I have to let the needle come out near the bottom of the wound, and then re-insert it, finishing the complete introduction. This is necessary on account of the needle being shorter than the width of the wound. Now, as to the apex of the axilla: I use a catgut suture, and bury it in the tissues of the entire bottom of the wound. The needle is pushed up through the pectoral muscles, sometimes coming out quite near the clavicle, and it is then carried back, so as to take hold of the rest of the bottom tissues of the denuded surface, and finally brought out in the anterior flap, just opposite its point of insertion. The case may require two or three of these long and deep catgut sutures. When the sutures are all in place, the cut surfaces are carefully cleaned of any blood and kept as dry as possible by the use of aseptic sponges. The suture near the lower end of the wound is tied first, and then the rest are tied in the order of their insertion toward the apex of the axilla. The catgut sutures are tied last. Then the cut surfaces are brought entirely and completely into apposition, so that the blood ceases to ooze, and so that there is no cavity left for the accumulation of blood under any circumstances. The floor of the apex of the axilla is brought into contact with its roof, and is securely held there by the catgut sutures. The edges of the flaps may now be adjusted more accurately by a few small aseptic sutures, inserted by means of a small curved needle. To illustrate the working of this plan, I will put on record the following cases:

Case I.—October 14, 1886, I saw Miss R——, of New York, with Dr. McCorkle, her physician, to consider the advisability of removing some enlarged tubercular glands of the left axilla. On the 16th of October I operated, assisted by Dr. McCorkle, Dr. W. F. Dudley giving the ether. The glands were well supplied with blood vessels, which bled freely. They were ligated with catgut as they were cut. The sutures in this case were horse-hair and catgut. The horse-hair sutures were used for the part of the wound of operation in front, and were inserted as above described, the curved needle carrying them being made to take up a layer of tissue throughout the entire surface of the denuded structures. The walls of the axilla about the apex were completely brought into apposition by two catgut sutures. The blood clots had all been carefully picked out, and the oozing surfaces had been sponged clean. There was no cavity left to contain blood, and the cut surfaces were held face to face in their whole extent, so that they could not bleed. Some cotton wool was put in the armpit, and the arm was placed by the side, and held there by a roller bandage. The fore-arm was kept in a sling. The dressings were removed at the end of six days, when complete union had taken place. The stitches were removed; the catgut had been absorbed. There had not been any oozing from the wound. In this case the axillary artery was laid bare for about two and one-half inches.

Case II.—Mrs. B——, came to my office in May, 1887, having a large cancer of the left breast. It had been "drawn out" by a cancer doctor some ten months before. It had begun to ulcerate and bleed. I operated on the 30th of May, 1887, removing a very large mass from the left clavicle downward. At the same time I removed the entire contents of the left axilla, which contained enlarged glands and other abnormal tissue. In this case I did not use ligatures: The sutures, which were made of aseptic silk, were passed, as above described, through the entire surface of the operation wound, and performed

the office of ligatures, as well. Two catgut sutures were employed to approximate the floor and the roof of the apex of the axilla. The needle penetrated both the posterior and anterior walls of the axilla, coming out just below the clavicle, and being put in again close by, so that it could be carried back to a point not far from where it started. The armpit was dusted with iodoform powder, and filled with absorbent cotton, which was kept in place by a roller bandage. There was complete primary union of the entire axilla in four or five days; and the operation wound, in so far as the breast was concerned, also healed by primary union, except a small place near the clavicle, where the flaps could not be brought together.

Case III.—Miss A. C., aged 42 years, had a cancer of her left breast, which I removed October, 1887. December 7, 1887, I excised the contents of her left axilla, the glands beginning to enlarge. The hemorrhage was quite free, so that the hemostatic forceps were required for a short time; no ligatures were applied. Several aseptic silk sutures were put in on the plan above described; and two strong catgut sutures were put through the posterior wall of the axilla, and under a thin layer of tissue up to the apex of the axilla. They were both brought out just below the clavicle, and then were put in again close by, being carried downward through the pectoral muscles, and then out near the edge of the anterior flap. The clots were picked out of the wound of operation, and the surface was kept as dry as possible from oozing blood, so that the sutures, as they were tied, brought the clean-cut surfaces in contact. The catgut sutures brought the walls of the axilla near the arm and at the apex quite close together. The sutures acted as ligatures to the entire bleeding surface, as well as to the cut arteries. There was no cavity to contain blood left, nor was there any concealed bleeding. In this case, iodoform powder was dusted over the incision, after the insertion of a few co-aptation sutures, and some absorbent cotton was put in the armpit. The arm was bandaged to the side, and the fore-arm was put in a sling. Complete primary union took place in about a week.

The points involved in this plan of operation to get primary union of the axilla after removal of diseased tissues are simple, and are not difficult to put in practice.

First. Primary union requires that the fresh surfaces be put and kept in apposition, so that the new cells of the connective tissue may grow together as they form on both sides of a wound. The sutures, as I have put them into the walls of the operation wound in the case of exsection of the contents of the axilla above described, have accomplished this purpose.

Second. The thorough arrest of the flow of blood from cut blood-vessels and from oozing fresh surfaces of operation wounds is an important condition to promote the speedy formation of scar-tissue. The sutures, as employed in the above-described cases, accomplish these two objects in a practical and satisfactory manner.

Third. The soft aseptic compress in the armpit co-operates with these subjacent sutures in keeping the entire wound surfaces in apposition, and in arresting the flow of blood from the large cut vessels and from the oozing fresh surfaces.

The results of this plan of closing the axilla, when its contents have been removed, are very gratifying to the patient and very satisfactory to the surgeon. On the one hand, the patient is up and about in a few days, and requires only one or two dressings. On the other, the patient is not unfrequently kept for weeks with a profuse discharge from the axilla, and is annoyed by daily dressings of a painful operation wound, in which there is often severe inflammation. In order to obtain primary union of the axilla, the surgeon may require a little more time than he would occupy in operating for union by granulation. But this is only a trifle compared to the time taken to dress a suppurating axilla week after week.

Of course, there are conditions of the axilla in which it would be impossible to obtain primary union. But these conditions are somewhat exceptional. It seems to me that primary union may be obtained after the greater number of exsections of the contents of the axilla. When the general health is reasonably good, and when the wound-surface can be well freshened, and when the subjacent sutures are properly put in, and when the coaptation sutures are applied, primary union of the axilla will become the rule.

—The wife of Dr. Oliver Wendell Holmes died at her residence on Beacon street, Boston, on February 6, 1888, in the 69th year of her age. Mrs. Holmes was a daughter of Judge Charles Jackson, one of the Justices of the Supreme Judicial Court of Massachusetts, who sat on the bench from 1813 until 1824. His daughter was married to Dr. Holmes in June, 1840.

PECULIAR CASE OF STRANGULATED HERNIA; OPERATION; RECOVERY.

BY MONTGOMERY LINVILLE,
NEW CASTLE, PA.

Miss Lizzie S., about 26 years of age, had occasionally noticed an enlargement in the right groin for six years. As it always disappeared in a few hours, and gave her but little pain, she failed to consult a physician until May 2, 1887, when the tumor became so large and painful that she sent for me in great haste. I found her suffering with violent cramps and vomiting, caused by a large inguinal hernia on the right side. I succeeded in reducing it in a few minutes, and as it entered the outer ring there was a distinct snapping or tearing sound, which I could not account for at the time; but later developments fully explained it. I applied a suitable truss, and warned her of the danger of neglecting to wear it. As long as she followed my advice she had no trouble. About the middle of July she became careless, and neglected to wear the truss. The result was that she again sent for me to reduce the hernia; but my efforts were not attended with the same success as on the first occasion. I gave her a hypodermic injection of morphine to relieve pain and vomiting, hoping it would relax the parts sufficiently to enable me to succeed during my next visit. But this hope was vain. I then administered chloroform, and after repeated efforts succeeded in reducing the hernia to about one-half its original size. As this gave her considerable relief, I continued the hypodermic injections of morphine, and finally succeeded in reducing the hernia on the third day. I then explained to her the importance of always wearing her truss, and stated that if she neglected to wear it, sooner or later an operation would be necessary.

But once again she disregarded my advice, and about the middle of September, 1887, while moving a wash-stand, the hernia again came down; she went to bed, and for thirty-six hours made a heroic effort to reduce the hernia herself, as she was loath to send for me on account of her disobedience. But violent cramps and vomiting forced her to do so. On visiting her, I found the hernia much larger, and more tender and painful than on the previous occasions. I should have operated at once, but my former experience made me hope that I could reduce the mass, and caused me to delay until the third day. By this time her symptoms became so alarming that I was forced to operate, assisted by Drs. James Wallace and Joseph Cooper, of New Castle. I cut down to the sac and found it firmly adherent, and that it extended from the external abdominal ring obliquely to the crest of the ilium. I succeeded with difficulty in breaking up the adhesions; but I found the neck of the sac so firmly contracted with bands of adhesions, and in such an unhealthy condition—being almost black—that it would be necessary to excise it. I proceeded to open the sac, and for a few moments was horrified with the thought that I had made a mistake and cut open the bowel, for several dark colored semi-round bodies appeared, about the size of a plum, and resembling lumps of fecal matter; but, after a more careful examination, we discovered that they were lymphatic glands in a partially broken-down condition. Immediately under the glands I found the strangulated loop of bowel, and easily pushed it up into the abdominal cavity. The sac, and especially its neck, being in a very unhealthy condition, I excised it as high up as possible. But I could not remove all of the diseased portion, as there was evidence of a local peritonitis on the right side. There was very little hemorrhage, so I inserted a drainage tube and closed the wound with deep sutures, and applied an antiseptic dressing. I had but little hope that my patient would recover. Everything was against her: the delay in operating; a delicate constitution; the diseased condition of the sac; and especially the local peritonitis. But she did gradually recover, and eventually regained perfect health.

The after treatment consisted in keeping the patient under the influence of opium. Morphia, given hypodermically, seemed to agree with her best, and I gave large doses —half a grain three or four times every twenty-four hours, for the first week. I gradually reduced the dose during the second week, and discontinued it on the fifteenth day after the operation.

The fact that we found three lymphatic glands in the hernial sac is the most interesting part of this case. The query is, how did they get there? My theory is that they became firmly adherent to the peritoneum—the hernia being of long standing—when I first reduced the mass of intestine, which was four and a half months before the operation; the glands were torn from their natural attachments, and were forced up into the abdominal cavity with the peritoneum. This supposition would account for the peculiar snapping or tearing sound which I heard on that occasion. The next time the hernia came down, the peritoneum came first, then

the glands and the bowel; thus the peritoneum formed a regular pocket for those glands. They were in this position four and a half months, slowly breaking down. For some weeks before the operation the patient complained of soreness and pain in the right side, no doubt caused by a subacute local peritonitis. I have never met with, nor heard of, a similar case. For this reason, and because my patient recovered under the most unfavorable circumstances, I have consented to write this brief history of the case.

If any of the readers of the MEDICAL AND SURGICAL REPORTER have met with a similar case or cases, I would be glad to hear from them.

TREATMENT OF LAME BACK—LUMBAGO.

BY CLARENCE G. HOLLISTER, M.D.,
MEADVILLE, PA.

About three years ago my attention was directed to the number of cases coming under my observation, in which men who were habitually exposed to all sorts of weather, and accustomed to laborous work, would come to me complaining of severe pain in the lumbar region, over the region of the kidneys, which was worse in the morning. Almost all my patients said that they did not put forth great effort on arising from bed in the morning, they could not have gotten up strength to start about their work. They all said also that the pain and lameness passed off to a certain extent as they were at work during the forenoon—although not entirely—only to recur on the following morning. Nearly all had a diagnosis ready for me, which was invariably: kidney disease. However, it seemed easy for me to diagnosticate muscular rheumatism. I had had two or three cases which had proved most stubborn, when the patient, whose case I will now describe, came to me for treatment. His case, which is a fair representation of others which followed, had extended over a period of two years, and his sufferings were so severe that I felt as if I must try some new combination of remedies.

The patient, H. E., male, about 45 years old, a cooper by trade, presenting the appearance of a hard-working and rather weak-looking man, came, almost creeping up into my office, and with his hand at his back, gradually settled down into a chair, and prefaced his request for treatment by informing me that he had suffered so with "kidney disease," or pain in his kidneys, that one-half of the time, during the past two years, he had been unable to work, and the other half he had been obliged to keep his young son at his shop to stoop for him and to hand him the necessary articles while he stood up and, with the greatest effort, made barrels to support his family. He had been under the care of many physicians, and as he was no better he was almost despairing. A careful examination did not reveal the least trouble in his kidneys, so I concluded the case was one of muscular rheumatism. In his treatment he had been given almost everything regularly known for such cases, and I therefore placed him upon the following prescription, without much confidence that it would relieve him:

℞ Potass. iodidi.....ʒss
Potas. bromidi.....ʒss
Tr. colchici sem.....fʒiss
Syr. aurantii cort.....fʒij
Aquæ..... ..... q.s. ad.fʒvi
M. Sig.—One teaspoonful three or four times a day, or increased, until the bowels are slightly acted upon.

I had no great hope of success with this prescription, as I had used the same ingredients in other combinations in a number of cases before. But I sent the man home with the instructions to report in about one week. At the end of this period he did report, and was able to walk quite comfortably to my office and let himself down into a chair less cautiously than before. The improvement was marked, and I advised him to continue using the medicine. After this the patient improved so fast that when he had taken three or four bottles he declared himself well; and now, for three years, he has not been laid up for one single day, and can do as big a day's work as ever. Once every three or four months he takes, of his own motion, a small bottle of the medicine, as a sort of preventive.

This case being well known in the community, not less than eighteen or twenty cases came to me during the following two or three years, all complaining in a like manner, though some cases were not as bad as this one. All of them had lasted over a year. Among the patients who followed the cooper was a locomotive fireman, who had made up his mind to abandon his engine because the pain and lameness in the muscles of his back were so bad, paper-hangers, a blacksmith, a few farmers, etc. All but two were relieved promptly by the above combination.

There is nothing new in the use of the remedies named above, but combining them in the manner stated was new to me. The striking feature of my experience is the

fact that cases of muscular rheumatism of the lumbar region, which are usually so tedious, were promptly relieved and remain relieved up to the present time. The consequence has been that the remedy became so well known that my druggist often spoke of putting it up in bulk and handing it out *ad libitum* to all persons suffering with lumbago. But the demand for it died out with the scarcity of cases, as about all the cases of this sort of "lame back" in this neighborhood had tried the remedy and were pretty well relieved.

In closing, I will say that no simple formula ever gave me such uniformly good results as the above did in the cases for which it was indicated.

HEMORRHAGE FROM HANDS AND FEET IN AN INFANT; PELVIC CELLULITIS IN THE MOTHER.

BY E. C. HELM, M.D.,
CHICAGO, ILL.

Early in November, 1887, Mrs. K. was confined, being attended by a midwife. On December 4, I was called to see the child, being told that it was "bleeding from the hands and feet." The mother was sitting up in bed, sweating profusely, and the midwife informed me that she was "convalescing from blood poisoning." Her previous history, I learned, had been that of fever on the third day, with scanty lochia and a small flow of milk, with some abdominal pain and uneasiness. She had been better the last few days; in fact was under charge of another physician when I was called in to see her child.

The child was very pale and bloodless. On removing the blood-stained bandages from its hands and feet, I observed that the blood transuded through the skin of the palms of the hands and the soles of the feet. The blood did not readily coagulate, and was very thin, resembling bright red serum. I ordered frequent astringent washes and powders, and nourishment to be given.

In a few hours I was summoned again, and found the palmar and plantar hemorrhage had ceased, but an abundant hematemesis taking place. The blood vomited was dark and thick. A few hours after this was checked, the palmar and plantar surfaces began to bleed again. I was unable to control the hemorrhage from the stomach, and hands and feet, at the same time, for longer than a few hours, as checking it at one place invariably caused a hemorrhage at the other.

The child died in forty-eight hours. The remedies used were ergot, aromatic sulphuric acid, internal and external astringents and plenty of food, but all were of no avail. The child either bleed internally or externally the greater part of the time, but never both at once. When the hemorrhage was external, it was always from all four of the surfaces mentioned, never from one or two of them.

The mother's condition had improved and the other physician was dismissed. About the middle of December, and six weeks after delivery, I was again called, and found the patient in bed, with high fever and great pain in the region of the uterus, especially on the left side. The uterus was immovable, the *cul-de-sac* of Douglas was full and tense, but showed no signs of fluctuation. The entire pelvis, especially to the left of the uterus, was filled with the exudate. Under treatment the woman rapidly improved for three weeks, when suddenly, two hours after I had seen her, she was taken with severe pain in the region of the left ovary, and it was several days before this pain was under control. The temperature, which for the last week had been nearly normal, jumped to 104°. There never was much tympanites. A hard, sensitive mass could be felt externally, and bimanual examinations showed it to be as large as a goose's egg. It appeared to be in the folds of, or just back of, the left broad ligament, probably the latter. This grew larger for two weeks, and then the patient informed me one day "that the lump was gone." Learning that there had been no discharge of pus, I was considerably puzzled. She said the urine had been rather thick, but she had thrown it away.

Securing a sample as soon as possible, I found, under the microscope, a few pus cells. The diagnosis of rupture into the bladder was now clear. In a few days the fullness and pain returned, but they soon subsided. This process was repeated ten or a dozen times, as the opening into the bladder was doubtless small, leading to frequent refillings and evacuations of the pus cavity. From this time the pus cavity became smaller and smaller, until, three months after pus was first discovered in the urine, the microscope occasionally failed to show pus; and in another month none whatever could be found. The tumor had disappeared, the uterus regained much of its mobility, and the patient was convalescent.

This case was very interesting to me, and so I send it to the REPORTER. As the child nursed the mother while she was suffering from blood poisoning, it has been my opinion

that its sickness and death were due to the poisoned milk; although I have never heard of a case having this peculiar variety of hemorrhage.

Society Reports.

PHILADELPHIA COUNTY MEDICAL SOCIETY.

Stated Meeting, January 25, 1888.

The President, J. Solis-Cohen, M.D., in the chair.

Dr. Edward Martin read a paper on

Ichthyol in Surgery.

Ichthyol was first described by Schrötter, and used in the treatment of skin diseases by Unna. It is obtained as a clear yellow-brown oil by distilling bituminous matter found in the Tyrol, and containing the fossilized remains of fishes and marine animals. By the action of sulphuric acid on this distillate, and subsequent neutralization with soda or ammonia, either the sodium or ammonium sulphichthyolate is produced. The latter compound is preferred by Unna. The ammonium sulphichthyolate is a reddish-brown, clear, syrup-like liquid of burning taste and odor, soluble in water, making a clear red-brown solution, and also soluble in equal parts of alcohol and ether. The ichthyol preparations are characterized chemically by their richness in sulphur (ten per cent.), so intimately united that it can only be extracted by complete decomposition (Lartigau); they easily take up oxygen, acting as powerful reducing agents (Baumann).

Clinically, the ichthyolates are described by Unna as being powerful antiphlogistics, causing anæmia and rapid subsidence of swelling in all tissues. This antiphlogistic effect is ascribed to the drug's action on the endothelium of the blood-vessels, depriving it of oxygen in virtue of its reducing properties, and contracting the lumen of the vessels. This explanation is not perhaps entirely satisfactory, but physiological studies have not yet given us a better one. The cornifying effect of the drug on the epithelium of the rete is undoubted.

Surgically, what are the indications for the drug? Lartigau states that it is indicated in all subcutaneous and inflammatory tumefactions, œdemas, vascular dilatations, incipient furuncles, and local manifestations of rheumatism.

Elliot praises it highly in burns of the first and second degree (five per cent. solutions in water), as producing rapid subsidence of pain and inflammatory symptoms. He finds its application to obstinate varicose ulcers associated with eczema rubrum (sodium compounds, three to five per cent.) at times productive of marvellous results. In his hands it is also useful in cicatrices, and in a few cases of rheumatism and neuralgia has given immediate and marked relief from pain. Schweninger states that in rheumatism, lumbago, ischias, tic, gout, and migraine, local applications of ichthyol act more powerfully in allaying the pain than any known medication. Lorenz is astonished at the fabulous efficacy of the drug. In acute and chronic joint-rheumatism, acute muscular rheumatism, mastitis, panaritis, and contusions, a few rubbings, with pure or fifty per cent. ichthyol compounds, are peculiarly successful in allaying pain and hastening healing. In chronic and acute joint-rheumatism relief often follows a single rubbing, while this is the rule in acute muscular rheumatism. The pain of gout disappears, the shining red skin becoming quickly wrinkled. A beginning mastitis or panaritis is always aborted, or if fully developed, the pain is much relieved. Its prompt use prevents the discoloration following contusions. It immediately allays the pain of a burn and prevents blistering. Finally, a ten per cent. solution hastens the cicatrization of badly-healing ulcers. Loring dilutes the drug with water when pure ichthyol compounds cannot be borne, and prevents irritation of the skin by careful washing and drying before each application.

Von Nussbaum states that a single application of ichthyol one part, water four parts, lanolin five parts, has allayed the itching of eczematous ulcers which had resisted all known applications for weeks and months, and promptly brought about rapid cicatrization on being continued a few days. Arthritic pains, which for weeks have made day and night miserable, are relieved at times in one-half minute after the application of a strong ichthyol ointment. In erysipelas it produces results obtainable by no other means, namely: the immediate arrest of the disease. Von Nussbaum's treatment was first the thorough disinfection and drainage of the wound, then, if the disease continued to extend, over its whole surface a thick layer of ichthyolate and vaseline, equal parts, was spread, and covered by a layer of ten per cent. salicylated cotton. The erysipelas advanced not a line further, and in a single

day the swelling disappeared, and the red, shining, puffy surface became yellow, brown, and wrinkled. This remarkable effect Von Nussbaum ascribes not to the influence of the drug on Fehleisen's cocci, but rather to a change produced in the tissues, by virtue of which they cease to favor the growth of the micro-organisms. Stelwagon has had excellent results in the abortion of furuncles by ichthyol preparations.

Agnew (D. Hayes) considers the ichthyol preparations more powerful than any known therapeutical agent in bringing about reduction of inflammatory enlargements, and has had particularly good results in recently enlarged lymphatics. He uses sulphichthyolate of ammonia and iodide of lead, equal parts, applied generously and covered in by oiled silk.

The writer has used ichthyol in: (1) Six cases of cervical adenitis, with absolutely no relief; cure being subsequently brought about by iodine or the knife. (2) Fifteen cases of marked inflammatory induration of the subcutaneous tissues, with invariably a speedy and in some cases almost magical reduction, and this after other means had been tried unsuccessfully. (3) In two cases of furuncles without good effect. (4) In one case of cellulitis without marked effect till the knife was used. (In this case staphylococci were found, but no chains.) (5) In four cases where pain was the most marked feature of inflammation, with complete relief in three and no effect in the fourth. (6) In one case of erysipelas of the scalp, with immediate cure. The latter is so striking that it is reported in full:

B. C., bartender, aged thirty-six, a full-blooded Irishman, was struck on the head by a bottle whilst intoxicated, December 20, 1887. Two slight wounds of the scalp were inflicted, to which no dressing was applied. On Dec. 22, the symptoms were chill, fever, nausea, great pain in the head, and swelling. He then went to a clinic; wounds were opened, disinfected, and catgut drainage provided; symptoms progressive. He was seen by the writer on the second day of his fever, the fourth from the infliction of the wound. He had had no sleep for two nights; the pulse was 106; temperature 103°; violent headache; whole scalp puffy, œdematous, and very tender; a few drops of thin pus were squeezed from the wounds. Cover-glass preparations of blood from puncture by tenotome showed Fehleisen's chains. A saline purge and iron were ordered internally. On the scalp was placed a thick layer of ammonium ichthyolate and vaseline, equal parts. The pain was relieved almost immediately; the patient slept comfortably; his temperature the following morning was 98°, and he was and remained well.

This is not different from the results obtained by Nussbaum. With the exception of the case of erysipelas, the writer used a ten per cent. ointment of ammonium ichthyolate in lanolin, fearing lest, in the case of stronger applications, his effects might be ascribed to counter-irritation. It is possible that stronger preparations would have proven efficacious in the treatment of cases of adenitis, in which the weak ointment signally failed. The extravagant praises bestowed by some authors on ichthyol savor more of proprietary advertisements than scientific contributions, and the variety of affections for which it is recommended might well make one doubtful as to its complete efficacy in any single instance.

An analysis of the cases in which it has proven serviceable will show, however, that they can be relegated to one of two classes: 1. Affections characterized by inflammatory enlargement. 2. Affections characterized by pain of peripheral origin, probably depending on inflammation or congestion.

For either of these conditions, theoretically, a powerful antiphlogistic would be indicated, so that the clinical indications for the use of the drug correspond to its alleged therapeutic effect. When the surface is irritated, weak solutions (three to five per cent.) should be used; but when the skin is intact and the subcutaneous tissues are to be affected, pure or one-half strength ointments give the best results. In using strong preparations the skin should be washed with soap and warm water, and thoroughly dried before each application. Ichthyolates can be combined with any of the ointments, or can be dissolved in water.

The writer's success with the drug, even where it was not used in the most efficient manner, has convinced him that the praise bestowed on it by the Germans is well merited. Where suppuration has actually taken place the weak ointment is not of service, but in the allaying of inflammatory pain and the resolution of subcutaneous induration (excepting adenitis) the results are most satisfactory.

Dr. A. J. Downes read a paper on

Some Interesting Sequelæ of a Case of Scarlet Fever, with Pathological Specimens.

On November 15, 1887, at 3 P. M., I was asked to see B. M., a boy of seven years, then under the care of a homœopathic practitioner, and said to be dying of heart disease. I called

immediately. The boy was comatose; had been so for twelve hours. The face had a characteristic pallor, the eyelids were slightly puffy, the pupils dilated, the breathing stertorous. I listened to the heart, and heard a loud systolic apex murmur, a diastolic one at the base, and mingling with both a peculiar whistling sound, the cause of which at the time I did not understand. Examining further, I found that the eyelids had become puffy two days previous, that the feet and ankles were now swollen, and the scrotum slightly so. No urine had been passed within twenty-four hours. Excepting a few scybala, forty-eight hours before, the bowels had not moved in seventy-two hours. The child had had scarlet fever five years before. I told the father that the boy did have heart disease, but that he was dying of uræmia. Shortly after 5 P. M. the boy was dead. The following morning Dr. Martin Rively and I made a post-mortem examination. The specimens I show are the heart, kidneys and a piece of the liver. So advanced cardiac lesions in a child of this age are far from common. The ventricles are both hypertrophied and the cavities dilated; the right considerably. The curtains of the mitral valve are thickened and fibrous, the posterior leaflet is exceedingly contracted, and shows above it a recent inflammatory area. The aortic curtains are a beautiful picture of an insufficient valve. The whistling sound I heard during life must have come from the tricuspid valve. The hypertrophy of the muscular elements of the ventricle, with the marked distention to which the cavity was subjected, surely allowed sufficient leakage to cause this sound.

On account of its so late recognition and its undoubted influence in enhancing the cardiac condition, the state of the kidneys is exceedingly interesting. Even macroscopically the kidneys show changes which must have been going on for some time. The pale cortex and the eversion of the cut edges indicate fat. Under the microscope we find evidence of long existing changes, sufficient to warrant the assumption that the kidney changes began in the long-ago attack of scarlet fever. The tubules are swollen, distorted and full of casts. The epithelial cells lining them are somewhat granular and smaller than normal, with their nuclei becoming indistinct. Long existing changes therefore exist. We find also recent conditions. The glomerules are swollen and congested, and in their vicinity an infiltration of small indifferent cells—a very characteristic glomerulo-nephritis of recent date—which was the cause in this case of anuria and consequent uræmia. And the history points to this; for the boy, although not well for a few years back, was comparatively so. For two weeks previous to his death he was confined to his bed, and undoubtedly during this time he was suffering from a glomerulo-nephritis, which, adding itself to an already damaged kidney, precipitated an attack of uræmia. Additional proof that the boy's kidneys were not normal prior to his last sickness is not wanting. His bladder, on post-mortem examination, was found to contain about two ounces of urine—the accumulation of twenty-four hours—of this I collected one ounce. It contained a large amount of albumin, but no sugar; round and columnar epithelial cells, showing fatty degeneration; a few epithelial casts containing oil globules and some free oil. A few weeks' nephritis could not cause this condition of the urine. The liver changes are secondary to the heart condition. Under the microscope it shows both fatty infiltration and degeneration.

In concluding, I would recall the points that interested me in the case. 1. The extensive cardiac lesions caused by scarlet fever occurring in a child under two years. 2. The late recognition of the heart affection; the non-recognition of the kidney condition. 3. The occurrence of acute inflammation—the glomerulo-nephritis almost typical of scarlet fever—in an already damaged kidney. Finally, may I not call attention to this case as showing to what extent the sequelæ of scarlet fever may advance when not recognized and treated. And the history of the past proves such to be the fact. Eight homœopaths in succession had charge of the boy for four years prior to his death. Over a year ago one had diagnosticated diabetes. The one in attendance before my visits had recognized valvular affection. But the kidney lesions had escaped them all. Apparently this proves that the case ran an almost natural course.

Dr. James Tyson exhibited

Fleischl's Polarizing Saccharimeter,

made by Reichert, of Vienna, and explained its use. The deviation is indicated by the displacement of a dark band continuous in two parallel spectra, when no glucose is interposed and the instrument reads 0. When a column of sugar is interposed a deflection takes place, and after the continuity is again restored the *percentage* of sugar is read off from the vernier.

Dr. Tyson said the polarizing saccharimeter could not be recommended for testing qualitatively very minute quantities of sugar, say anything less than one-half of one per cent.,

Fehling's solution being really more delicate. Nor can it be said that there is any saving of time in testing qualitatively solutions contain less than one per cent. The advantage of its use is shown in determining from day to day the quantity of glucose in specimens containing considerable amounts, where the requisite dilution and titration occupy much time. In very clear urines it is not necessary, with Fleischl's instrument, to decolorize with acetate of lead solutions, but where they are not almost colorless it is necessary to treat with basic acetate of lead in the proportion of 1 c. c. to 10 of urine and filter, when one-tenth should be added to the reading of the vernier.

In opening the discussion, Dr. L. Wolff said: The instrument to which Dr. Tyson referred, and which I had the honor to bring before you here, is known as a polarization microscope, though this is an improper term, as it is simply the utilization of the microscope stand for the adjustment of the parts of a polarizing saccharimeter. I imported the parts constituting this about a year ago from the manufacturer, Paul Waechter, of Berlin. Its principal advantage is that of price, which, to the best of my recollection, is about twenty-five dollars when bought here. Like all other saccharimeters it consists of a polarizer which, as you see, is attached to the substage; on the top of this fits a plate consisting of two demi-disks of quartz of opposite rotary power, which let the intersecting line be readily seen through the analyzer. This latter, with the vernier and nomus, fits into the microscope instead of the draw-tube. The analyzer or scale can be so adjusted that when the nomus points to 0° the two semi-disks will be of an even neutral violet tint. In this position it is fixed with a screw. The tube is then withdrawn and the glass container with the urine is screwed in, when the whole is replaced. In looking through the instrument it will now be seen that the two semi-disks are no longer of neutral tint, but one is red and the other blue. On the rotation this inequality of color will disappear at a certain point, and when the neutral violet tints are again seen, the angle is read off. With this angle you can refer to the accompanying table and read off the amount of sugar present in grains contained in one litre, or by dividing this by ten the percentage will be arrived at. I have used this little instrument a great many times and find that it is quite as accurate as the larger and more expensive apparatus.

It is my custom to make about six readings, which is very rapidly accomplished, and take the mean thereof by dividing the sum of the readings by six. With some practice and an eye trained for color, the results come generally within one-tenth of one per cent. of the amount of sugar present. Like every other instrument, it requires practice to get good and accurate results. While for those who have to make many quantitative determinations of sugar in urine, the polarizing saccharimeter offers great advantages, I quite agree with Dr. Tyson that, for single and isolated determinations, Fehling's method is quite as rapid and certainly as reliable. The general use of the polarizing saccharimeter, together with its advantages and disadvantages, and also the preparation of the urine for that purpose, have been so fully explained by Dr. Tyson that there is nothing further for me to add.

NEW YORK ACADEMY OF MEDICINE.

Stated Meeting, February 2, 1888.

The President, A. Jacobi, M.D., in the chair.

Dr. Robert W. Taylor read a paper on

Xeroderma Pigmentosum, and its Relation to Malignant New Growths of the Skin.

The author continued the histories of seven cases of xeroderma pigmentosum which he had reported in two papers, the first published in 1877, the second in 1878, showing their further development and relation to malignant new growths of the skin, and also gave a synopsis of cases reported by other observers in different countries, the entire number being thirty-nine. One other was excluded as having an incomplete history. The first paper on the subject of xeroderma pigmentosum was published in a text-book by Hebra and Kaposi in 1870. A good proportion of the entire number of cases observed had been reported by American physicians. The name xeroderma pigmentosum was not altogether satisfactory, but it probably would remain because of its brevity. The parents of all of Dr. Taylor's cases were dark brunettes; those of six were Hebrews; they were healthy; all the children were dark complexioned and had dark hair, except one. Three were sisters, and their parents were cousins. Two others were cousins of these, and their parents were second cousins. One patient had died of drowning before the development of malignant disease. Three of the others had epithelioma on some part of the face. The clinical history in the seven

cases was very similar, and was clearly portrayed. The disease consisted in telangiectasis, pigmentous and atrophic changes, which had close anatomical relations. To these polymorphous lesions were superadded new growths, which at first were benign in character, but which might become malignant. In six of his cases, according to reliable testimony, the disease began about the fifth or sixth month of life, and in one at the fourteenth month. He was skeptical about three cases reported as xeroderma pigmentosum beginning at the sixteenth, ninth, and ninth years respectively. The development of epitheliomatous and other malignant growths on the face of persons subject to deep or light pigmentations did not necessarily constitute xeroderma pigmentosum. The weight of evidence, therefore, placed this disease as one of very early childhood.

The invasion of xeroderma pigmentosum was very constant, beginning about the face and under the eyes as a well-marked smooth superficial erythema, which was often regarded by parents as the result of sunburn. The patches gradually spread over the face and neck and stopped abruptly at about the third rib. Its duration varied from one to seven months, during which the erythema might become less red, while pigmentous patches developed, at first of light-brown, then becoming darker, perhaps black. They varied in size from that of a pinhead to that of a lentil. Scattered among them were telangiectasic spots. With the evolution of these lesions there were no marked local subjective symptoms. If the case were carefully studied and frequently observed in these irregular patches, it would be very often plain to the eye that the pigmentary spots followed exactly upon the pre-existing red spots, and the conclusion would be obvious that the red lesion was its forerunner and its pigmented fellow its sequel. These lesions had exacerbations and remissions. As the child grew older the disfigurement became worse. There was no record of a case in which anything like an amelioration in its course had been observed. In the milder cases there was liability later in life to severe lesions.

The telangiectasis and the pigmentation were lesions of what might be called the hypertrophic stage of xeroderma. In some cases there were soon superadded atrophic changes. In the majority of cases these began at about the end of the first year. Their course was subject to marked exacerbations and remissions. They were not symmetrical on the two sides. As they progressed, they produced hideous deformities by reason of the size and situation of the patches. The skin became reduced to the thinness of parchment; nearly all the follicles were destroyed; vessels could often be seen beneath. The hands and arms, feet and legs, showed the changes less well marked. Atrophic changes were especially liable to be marked upon the forehead, scalp, eyes, nose and mouth, and might create partial stenosis of the nose and mouth. It was an interesting fact that when the atrophic process was at an end, no further pigmentation took place. Excessive hypertrophic changes took place very often coincident with the atrophic changes. There were also found epithelial new growths in rudimentary form, which might go on to malignant new growths. These tumors were liable to fall off and leave a fungous, oozing surface, which might become malignant. Such tumors and oozing surfaces should be removed or scraped by the sharp spoon. Of the thirty-nine cases, malignant new growths were known to have developed in sixteen, and non-malignant growths in six. Of course, the latter might yet become malignant, and some not yet affected by malignant or non-malignant growths might become so. Most of the new growths developed before the tenth year; there was nearly equal tendency to them between the tenth and twentieth years. There had been no evidence of metastasis during life or at autopsy.

The author thought the facts in the cases bore out Kaposi's explanation of the occurrence of epithelioma at so early an age, viz.: that it was due to the rapid changes going on in the epithelial layers. No successful remedy had been found. Surgery should be resorted to for the removal of tumors and fungoid surfaces. The sooner they were destroyed, the less the likelihood of their change into malignant new growths.

THE PRESIDENT suggested the use of arsenic and phosphorus in treatment, for the purpose of causing nutritive irritation in the connective tissue, which seemed to be lacking, probably because of failure of embryonic cells to undergo their usual change after birth.

—The Otological Congress will be held at Brussels from the 10th to the 15th of September next, and it will be followed by the meeting of the German doctors and naturalists at Cologne. Dr. C. Goris, 143 Rue Royale, Brussels, will receive all announcements for the Otological Congress, which may be sent to him.

Reports of Clinics.

COLLEGE OF PHYSICIANS AND SURGEONS.

MEDICAL CLINIC—PROF. DELAFIELD.

Two Cases of Incipient Phthisis.

Case I.—At the Vanderbilt Clinic, January 12, 1888, the first patient introduced by Prof. Delafield was a young man who gave the history of a single hæmoptysis. After the physical examination, Dr. Delafield said: The patient is a very good example indeed of a class of cases we see more frequently in private practice than in dispensaries and hospitals. We find, often enough, patients coming to us with just the history which this man gives: a young man or a young woman who has been in ordinary health, with no cough, no running down, suddenly coughs up a little blood. The quantity of blood which such persons will cough up varies; it is, as a rule, not great; it may be only a few mouthfuls; it may be a cupful. In some, there may be a history of only a spitting up of blood; in others, it may have been repeated two or three times, but each time only a small quantity is raised. Between the attacks they may have a little cough, but not much. These will be all the rational symptoms the patients will give. This young man continued to have a good appetite; he slept well at night; he did not feel sick. But, on the other hand, if the patient is of a more excitable temperament, you may rely upon some constitutional disturbance. Many such patients will tell you they have no appetite; they feel very weak; they do not sleep at night; they feel very badly. Now, all this means the individual; it does not mean the disease. In most of them you will find no rise of temperature; in a few, there will be a little rise. The pulse is usually rapid, somewhere about 100°, as in this young man.

After getting the history of these patients, the next thing is to examine the chest. In some of them you will get absolutely no physical signs of disease; in most of them there will be no change in the breathing or percussion note over the entire chest. In other patients, there will be physical signs, but they will be very slight indeed. In these patients there is no consolidation of the lungs. When you listen to the breathing you will, in some patients, get a little information. The locality at which you will get this information varies in different cases. In some, it will be just at the apex on either side beneath the clavicle; in others, it is lower down in front, but not in the intermediate position. In other cases it may be over the upper part of the chest behind. What you first notice is change in the character of the breathing; this change is perhaps impossible to describe in words, but there is a difference in the breathing over the two lungs. There may be added to the change in the character of the breathing a few subcrepitant râles—not many, but a few. Now, with these very few physical signs, or no physical signs at all, you will be called upon to say whether the patient has or has not commencing phthisis, and you see how very difficult indeed the problem is to solve. It is easier to solve in men than in women, for men are less likely to bleed in this way than are women without showing changes in the lungs.

Suppose the case of a young man, like the one before us; it will make a difference, in the first place, as to what the patient tells you of the character of the bleeding. If he has had a single large hemorrhage, taking place within a short time, it will not be as much an indication of commencing phthisis as if he had had several smaller hemorrhages. The more frequently the hemorrhages have been repeated, so much the more likely are you to find disease of the lungs. Then you have to look at the throats of such patients, and see whether there is marked evidence of pharyngitis. This young man has none at all. Then you inquire particularly whether there has been any change in the general health. Sometimes on close questioning you will find that although the patient has considered himself well, yet he has not been in as good health as for sometime before; he has been running down, losing flesh and strength. Still further, you will inquire into the family history, to find out whether there is any hereditary predisposition to lung trouble. Thus you try to get all the collateral information you can about the health of these patients before you make up your mind as to what is the matter. Still further, in interpreting the physical signs, if there be any, you must have some definite idea of what they may mean. For example, in this young man the only physical signs are, that behind, over the upper part of the right lung, there is a little change in the breathing, and there are a few subcrepitant râles. Now, in interpreting those physical signs, there are two points to be borne in mind, namely, the mechanical conditions which produce

them, and the significance which they possess. In interpreting these physical signs we must take into consideration the patient's history. If this patient had come here without any history of spitting up of blood, but simply complaining of a little pain over the right shoulder, I would suppose that the subcrepitant râle present here was due to fibrine on the pleura, and that very probably the man had only a localized pleurisy. But when I get the history of a young man spitting up blood for several days in this way, and in his usual health, I think those subcrepitant circumscribed râles mean something else; I think they mean either a little mucus or a little blood in some of the small bronchi of that part of the lung. The sound is just the same, but the way in which it is produced is different. But with the history given, I do not draw the inference from these physical signs that the patient has simply a localized bronchitis. The inference which I draw therefrom is that there are a few scattering miliary tubercles in the upper part of the right lung; these miliary tubercles, as such, not taking any part at all in the production of the physical signs.

It is hard to realize in these cases of early phthisis that what is really of consequence is not the part which at first gives the patient either the symptoms or the physical signs. It is not the fact that there are tubercles in the upper part of this man's lungs that is occasioning the hemorrhage. It is not their presence which is occasioning the subcrepitant râles; yet we know by putting such cases together over and over again that with such a history and such physical signs we may be reasonably sure that there are miliary tubercles in the patient's lungs. Still more than this, we may be pretty sure that if he had not miliary tubercles he would not have had the bleeding, and he would not have the physical signs.

I think, then, in this patient's case there is no question about the diagnosis. He has phthisis in its very earliest stages, consisting of a very few miliary tubercles in the upper part of the right lung. As a symptom of this change in the lungs he has had spitting of blood, which, by the by, comes from the bronchi of that lung, and from the larger bronchi, not from the lung tissue. With this bleeding from the bronchi there has been a very small degree of bronchitis, or perhaps no bronchitis at all. Perhaps the subcrepitant râles are due simply to a little blood which has been expelled from the larger bronchi into the smaller ones.

As to the treatment, I think one has to admit that such patients as these really can get well without doing anything at all. I think it is possible for a young man like this to stay in the same place, go on with his work, and have no further symptoms at all, and if he should die years afterward from some other cause, you would find in the upper part of his lung the miliary tubercles which are there at the present time, the disease not having progressed. This is, I think, possible for these patients; the probability, however, of their getting entirely well is very much decreased if the patient cannot take proper precautions in preserving his health. The best precaution of all is probably one which this young man cannot take, and that is getting the beneficial effect of change of climate. If you could do just what you think is the very best thing to do for a young man coming to you with such a history, and with such physical signs as these, you would tell him to go away for one or for two years, and during that time to travel about from place to place, not staying in any one locality, not looking out particularly for climates which are considered good for patients with phthisis, but simply getting the beneficial effect on his whole body of traveling and moving about from place to place. If he cannot do this, the best thing he can do is to try to remedy any defect which there may be in his general health. Take the case of this young man. He is sufficiently well nourished; that is, he has fair weight; there is no object in giving him cod-liver oil; there is no object that I know of in giving him stimulants. There are only two points about his case which suggest themselves to me as giving indications for treatment. One of these is his occupation. He is a cigar-maker. That unquestionably is an unhealthy occupation for a young person with lung trouble of this kind, as the dust from the tobacco is constantly being inhaled. He is still young, and if it is possible for him to take up some other business it would be very much to his advantage.

Then in color he is slightly anæmic; and this indicates the administration of iron. In this case, then, all that is necessary is to advise him to learn some other way of earning his living than working in tobacco, and have him for a time take iron in moderate doses.

Case II.—This case makes a sort of continuation of the one which we have just been considering. The man is 30 years old, and instead of raising blood only six days before coming under observation, he has been having hemorrhages during the last eighteen

months, but much in the same way as the other patient. Although the duration in this second case has been longer, yet you will observe there is the same paucity of symptoms as in the other. He has no cough except at the times he raises blood. He is not short of breath; he has no great amount of pain about the chest; his appetite is fairly good, but latterly he has lost flesh to some extent; that is all. Now in his case we ought to find more physical signs, and rather different physical signs from those we found in the previous case. There is a little depression under the clavicles, but it is about the same on both sides. You will notice the difference in the percussion note on the two sides. On the right, beneath the clavicle, the resonance is fair enough; but on the left the pitch is higher, and the sound is a little shorter. The breathing is not quite as loud on the left side of the chest beneath the clavicle as it is on the right, and the voice is decidedly more feeble.

This man began eighteen months ago, just as the preceding patient has begun recently, with a few miliary tubercles in the lung; but, instead of having them in the upper part of the right lung, he has had them in the upper part of the left lung. Whether he had any physical signs eighteen months ago or not, of course we do not know; but he had the same spitting of blood. He has gone on from that time to the present, spitting blood occasionally; yet, for the most part, not feeling sick; able to work; but latterly he has lost flesh. He says he could work, but he has nothing to do. When we come to examine his chest, we get the physical signs which we would expect to find with his clinical history. We no longer get any râles, although in other patients of this kind we might very well get some subcrepitant râles. All we get is dullness on percussion, not very marked, the breathing not as loud, and the voice not as loud under the left clavicle as under the right. These are the physical signs.

Now, what is the change which has taken place in his lung? It is a very limited one, indeed. It involves only the apex of the left lung. Here at the apex is the same moderate number of miliary tubercles as in the previous case. But, as this man's trouble dates back eighteen months, there has been time for changes to be added to those of miliary tubercles, and it is these other changes which give rise to the physical signs. In the first place, the pulmonary pleura is thickened over or just below the apex of the lung. In all probability, there are some adhesions between the pulmonary and costal pleura at this point. Then in the lung itself, besides the miliary tubercles, which still are few in number, there is a little diffuse fibrous tissue. It is not the tubercles which give us the dulness; it is the thickening of the pleura; it is the pleuritic adhesions and the fibrous tissue in the upper part of the chest which give us the difference in the percussion note, voice and breathing. It is easy enough to say why these changes produce the difference in the percussion note, but it is not by any means easy to say why they give the difference in voice and breathing. We know by experience that they do so; we see it, over and over again, that those are all the changes in the lungs to account for the voice and breathing being diminished.

In this man, then, we have chronic phthisis lasting eighteen months, yet at the end of that time he has but very slight pathological changes in the lung. In such a case as this the prognosis is comparatively good. It is perfectly possible for such a patient to get well. As to what we can do for him, the rule is just the same as in the preceding case. If it were possible for him to go away and stay away, it would be the best thing he could do. His occupation, when he has it, is that of a salesman, which is a good enough business for a man suffering from his trouble. Just now, unfortunately, he is out of work, and leading the very demoralizing life which belongs to a man without work. He has nothing to do all day, and he loafs about the house, and has not sufficient exercise either of body or of mind. He unquestionably would be better off if he had something to do. In the next place, in this man there is an indication for fattening food. He has lost flesh. He is somewhat emaciated. His lips are not particularly anæmic. I do not know that there would be any particular object in giving him iron. I would rather give him cod-liver oil.

—Dr. George S. Meigs, a dentist living in New York, killed himself Jan. 23, 1888, in his operating-room. He had become subject to extreme nervousness, which interfered with his work and kept patients from him. When utterly prostrated, he consented to try the so-called "Christian Science," in the hope that it might restore him to health. It failed, and in despair the wretched man put an end to his life. He made death sure by drinking enough prussic acid to kill twelve men. He stated, in a letter to his wife, that he wished to be cremated.

Periscope.

Contributon to the Etiology of Neuralgia.

In the *Edinburgh Med. Journal*, December, 1887, Mr. James R. Whitehall says there are many conditions classed under the heading neuralgia. There is the pure form, with no apparent and definite cause during life, and leaving no discoverable lesion after death; the reflex form, which may be, and frequently is, due to dental caries and other remote causes, the removal of which gives speedy relief to the symptoms. Then, again, there are other forms due to an actual inflammation of the nerve—a true neuritis and not a neuralgia at all; others due to poisons circulating in the blood, such as lead, the poison of syphilis, gout and malaria; and some to pressure upon the trunk of the affected nerve, or to an irritation still higher in the course of the nerve. In the pure form of neuralgia, where there is no apparent cause except the debility so frequently associated with it, the author thinks it is impossible to distinguish during the attack these three different kinds of pain: First, a more or less continuous throbbing pain; second, a sharp, lightning-like pain, succeeded frequently by a burning or tingling sensation; third, a superficial cutaneous hyperæsthesia, the "points douloureux" of Valleix. The throbbing pain he attributes to a dilatation of the vessels of the nerves themselves; the sharp, lightning-like pain to a more acute compression of the nerve, brought about by a sudden alteration in the blood pressure, or an increased dilatation of the already dilated blood-vessels, perhaps from such slight causes that they usually escape notice. With regard to the production of the tender spots of Valleix, the explanation is ingenious. As the nerve, he says, passes on its course, it gives off filaments to the surrounding parts, and these filaments come off from the main trunk in a definite order from without inwards; therefore the most superficial filaments of a nerve-trunk are those which supply the tissues in the immediate vicinity. But it is these very filaments which suffer most when a nerve is compressed in the osseous or other canal; and therefore, by the law of eccentric projection, there is a hyperæsthesia in the part supplied by those filaments—in fact, a tender spot. And since these filaments suffer most, it is not at all unlikely that, as the attack progresses, the prolonged pressure would temporarily destroy their function and cause local anæsthesia; and this is exactly what occurs—hyperæsthesia being more likely to occur at the earlier part of an attack, and anæsthesia later.

He considers the treatment of neuralgia under three headings, namely: 1, external local; 2, external remote; 3, internal.

1. Of the local methods of treatment, such operative methods as incision and division of the nerve sufficiently explain themselves. Stretching the nerve and acupuncture seem to act in the same way, probably by causing a solution of continuity in the sheath, and thus relieving tension, and diminishing the swelling of the nerve. As regards stretching, however, Callender considers that "it is probable that the stretching is of use by numbing the nerve for a short time." If this be really true, the natural explanation would be that the sensory irritation resulting from the hyperæmia would for a time cease, and on its cessation the reflex dilatation of the blood-vessels would also be brought to an end. Electricity, again, in common with belladonna and heat or cold locally applied would contract blood-vessels. Belladonna, volatile oils and their stearoptenes,[1] such as thymol and menthol, also chloroform, not only contract the blood-vessels, but also diminish the sensibility of the part, while aconite locally applied acts purely as an anodyne.

2. Of the external and remote methods of treatment, counter-irritation over the upper part of the dorsal spine, which apparently does good in some cases, must be mentioned, though perhaps somewhat difficult to explain, unless possibly it has some action on the sympathetic vaso-motor fibres which emerge from the cord about this level in the anterior roots of the lower cervical and upper dorsal nerves (Foster). Ligature of the carotid is an eminently successful, though somewhat heroic treatment, and has been very successfully employed by Dr. Patruban in many cases of severe neuralgia—this, of course, acting directly on the blood-vessels, the idea of the operation having originated from the relief obtained in some cases by simple pressure on the carotid.

3. Of the internal treatment of neuralgia the substances used fall naturally into four groups:

(1.) Those which contract blood-vessels, such as strychnia, atropia, and its allies, bromide of camphor, digitalis, ergot, volatile oils, such as turpentine, chloride of ammonium and quinine, though certain of these also have a specific action on sensory nerves in addition.

[1] Solid crystalline compounds separable from volatile oils by cold.

(2.) A second group consists of bodies which act as general tonics, such as quinine, iron, strychnia, phosphorus and arsenic. The experience, however, of arsenic and phosphorus seems to indicate that they have some more direct action than simple tonics.

(3.) A third group consists of simple anodynes or sedatives, such as bromide of potassium. This, however, like chloral, diminishes the pulse tension, and in addition diminishes reflex excitability by depression of the peripheral sensory filaments. Other drugs, such as cannabis indica and morphia, seem to act as simple anodynes.

(4.) The fourth group consists of the usual tell-tale drugs, which are always appearing, and of the action of which no very apparent explanation can be given. Amongst these gelsemium sempervirens is a prominent member, and probably also arsenic and phosphorus.

He concludes by saying that there are, then, symptomatic, pathological, etiological, and therapeutic reasons for believing that the blood-vessels are at fault in cases of neuralgia, and therefore, on this view, it seems necessary to consider true neuralgia as a sympathetic neurosis, affecting certain tracts of cerebro-spinal nerves, resulting in simple dilatation of the vessels of these nerves, brought about by unknown causes, or by reflex irritation, or possibly by the specific action of certain poisons in the blood.

Sulphate of Sparteine.

The *Deutsche med. Wochenschrift*, in a review of sparteine, remarks that it is the alkaloid of broom, and belongs to the alkaloids which have no oxygen in their composition. The sulphate is employed for medical purposes, because it is more easily soluble and less easily decomposed than the other salts. It forms large, translucent, colorless rhomboid crystals, readily soluble in water, and of a bitter taste. Germain Sée found that it possessed a stimulating action upon the contractions of the heart, slowing its action; and that it increased the arterial tension, and also increased the flow of urine. The rhythm of the heart's contractions was restored in only a few cases. The action of sparteine was rapid, but was not maintained sufficiently long at its height to remove the disturbances in compensation; and even when given in repeated doses does not achieve any such persistent action as is obtained through the use of digitalis. Voight, however, recommends it in valvular disease, with and without the disturbances in compensation which are proper to it. He also recommends it as a regulating and calmative agent, in insufficiency of the heart muscle without disease of the valves, in pericarditis, and finally as an adjuvant in combination with digitalis. The dose is about one-third of a grain, three times a day. The following formulæ are given:

℞ Sparteini sulph.....gr. iij
Aquæ destillat.....f℥ij¾
M. Sig.—20 drops in sweetened water or wine, two to four times daily.

℞ Sparteini sulph.....gr. iij
Syr. aurantii cort.....f℥iij
M. Sig.—Dose, a small spoonful in water, four times a day.

Saccharin in Diabetes Mellitus.

Kohlschütter and Elsasser report to the *Deutsches Arch. f. klin. Med.*, xli, S. 178, that in a case of severe diabetes affecting a man 30 years of old, which was treated with saccharin in daily doses of 15 to 30 grains, a considerable though transient diminution in the quantity of urine and sugar was brought about. During the employment of these large doses, anorexia persisted. The patient complained of a persistent disagreeable sweet taste, even when the saccharin was given in pill form, which taste hindered the taking of nourishment through the disgust it produced. The authors refer the diminution in the quantity urine and sugar excreted to the smaller quantity of food taken. But inasmuch as the saccharin effected no increase in the production of sugar, it may be used without injurious results to sweeten food and drink in diabetic patients. In one case in which the drug was given in this way the sweet taste of the saccharin was noticeable throughout in a disagreeable way.—*Centralblatt f.d. med. Wissensch.*, Jan. 7, 1888.

Case of Carcinoma of the Cervix in a Virgin.

Eckhardt reports this case to the *Arch. f. Gynecologie*, xxx, S. 471. It is interesting from the fact that a cancerous tumor, the size of a child's head, which arose from the hypertrophied posterior lip of the uterus, was found in a girl who was unquestionably a virgin. This tumor was removed by means of the galvano-cautery écraseur. The cause of the snout-shaped hypertrophy, as well as of the carcinoma, is stated to be chronic irritation from masturbation. At first the tumor was thought to be a carcino-sarcoma; but on microscopic examination epithelioid cells with large nuclei were found, not spindle cells.

Foreign Body in Wharton's Duct.

At the meeting of the Boston Society for Medical Improvement, November 28, 1887, Dr. A. T. Cabot showed a piece of brown straw, one inch and one line in length, and as large as a No. 5 needle, which had lodged for six months in Wharton's duct. The patient, a young man, lost a piece of straw under his tongue on the 14th of May, 1887. For three or four weeks he experienced no trouble from it. Then a somewhat painful swelling of the submaxillary gland upon that side occurred. When seen in August, the submaxillary gland contained a hard swelling about the size of a robin's egg, and in the line of the duct, about one inch from its orifice, was a little hard swelling as large as an apple seed. Pressure along the duct caused the issue of a drop or two of pus. The bit of straw being supposed to be very small and evidently lodged far back towards the gland, a cutting operation in search of it seemed unadvisable, and the patient was advised to press occasionally over the gland, and then along the duct, so as to force the pus and secretion out, in the hope of working the straw out along with it. This milking the gland and duct was followed by a decided increase of pain and swelling, but it was continued at intervals until October 1. At this time a little abscess formed over the duct, and was punctured by the patient. A few drops of pus appeared. On November 15, the patient found that when he gaped and raised his tongue, the duct was so shortened that the tip of the straw appeared at the orifice. After some trouble he succeeded in seizing the end with a fine pair of scissors and withdrew the straw.

Poulet, in his exhaustive work on "Foreign Bodies in Surgery," has succeeded in finding but six authenticated cases of foreign bodies in Wharton's duct. In one of these the foreign body was, as in this case, a bit of straw introduced while picking the teeth. A very severe inflammation followed in the case reported by Poulet, and, abscesses forming, the straw, which was two-thirds of an inch in length, was finally discharged spontaneously in two pieces. A careful search in this case at the time of opening the abscesses failed to find the straw. In answer to a question by Dr. Hooper, Dr. Cabot said that if he had suspected the size of the straw, he would have made an incision of the duct, and would have hoped to find it. The evidence at the time he saw the patient, however, was that the bit of straw was extremely small, and far back towards the gland, where the chances of finding it were but slight. As the patient was suffering no pain, it seemed better, therefore, to wait and try to work the straw forward to where it could be easily reached. That it was worked forward by the manipulation practiced seemed probable by the result.—*Boston Medical and Surg. Journal*, Dec. 22, 1887.

Chloroform and the Constant Current in Neuralgia.

Prof. Adamkiewicz says he has obtained marvellous results from the combined action of chloroform and the constant current in facial and other forms of neuralgia. The electrode is made of hollow charcoal into which the chloroform is introduced, and from which the current sends it into the tissues. That this power of penetration may be thus obtained is thought to be shown in the fact that when chloroform is colored with gentian violet and applied in the manner described to the ear of a rabbit, the tissue becomes dyed. In the experiments with the human subject, the writer notes, at the commencement, the triple action of the constant current, the chloroform and a condition of cataphoresis followed by a burning sensation and, finally, anæsthesia. Several remarkable cases of cure are cited. Anæsthesia was not obtained when the nerves were deep-seated, nor in sciatica.—*Progrès Médical.*

Tinea Decalvans.

At a recent meeting of the Academy of Medicine of Paris, a discussion took place on the contagiousness or non-contagiousness of tinea decalvans, but without much satisfactory result on either side. Dr. Ollivier has for the third time brought the subject to the notice of the Academy. The author protested vehemently against the exclusion in schools of the pupils who are affected by it, on the ground that it was not a contagious disease. Dr. Ollivier believes that tinea decalvans is caused by a sudden nervous perturbation, an unexpected emotion, or by very great sorrow. He would therefore recommend that the quarantine to which such pupils are subject should be removed, and that they should be allowed to prosecute their studies in common with the others. Dr. Hardy, the well-known dermatologist, declared that he entertained an opinion diametrically opposed to that of Dr. Ollivier. Prof. Cornil shares Dr. Ollivier's opinion, and stated that what tends to prove the non-transmissibility of tinea decalvans is that one does not find in this affection either cryptogams or micro-organisms, which could produce it.—*Lancet*, December 17, 1887.

Impaction of a Foreign Body in the Pelvis.

Upendra Nath Sen relates, in the *Indian Medical Gazette*, September, 1887, a remarkable case of impaction of a foreign body near the rectum. A washerwoman, aged 25 years, subject to epileptic fits, had an attack whilst in a standing position and fell over a bamboo. By the force of the fall a piece of a bamboo branch broke, and penetrated very deeply half an inch to the right of the anus. The wound proved to be very small, only admitting a probe, which entered to the depth of five inches; the presence of a foreign body could not be detected in it. As this, however, might have found its way into the rectum by the force of the fall, an exploration was made with the finger, whereupon a hard substance was felt in a vertical position by the side of the rectum, about two inches beneath the surface of the skin. The writer cut freely to the depth of two inches over the suspected part, and succeeded in feeling the end of the foreign body with a probe. He then enlarged the wound to the required extent, to facilitate the extraction of it, and with a strong forceps removed an entire piece of a bamboo branch four inches long and as thick as a full-grown finger. It is worthy of notice that the patient walked from her home, a distance of two miles, a fortnight after the accident. The woman is now doing well.—*Practitioner*, Dec., 1887.

Venesection.

At the meeting of the Clinical Society of Manchester, November 15, 1887, Dr. Addy (*Brit. Med. Journal*, Dec. 17, 1887) related three cases in which bleeding was performed, in two of which it rescued the patients from imminent death. The first case was that of a man, about 50 years old, who had suffered from hematemesis, cirrhosis, ascites and albuminuria. After recovery from these ailments, the patient, who had also aortic disease and high tension pulse, was seized with convulsions, lasting more than an hour; he became unconscious, cyanotic and breathed with great difficulty. About twenty ounces of blood were removed from the arm; the convulsions ceased, consciousness returned in twenty-four hours, and the patient had continued in good health for twelve months. The second case was that of an elderly woman, who was suddenly seized with violent coughing and dyspnœa, the lungs becoming rapidly engorged. On admission, the patient was almost pulseless, and apparently moribund. Venesection was performed, with almost immediate relief to the breathing, and the patient rapidly recovered. This patient suffered also from chronic Bright's disease. The third case was that of a young man, suffering from acute pneumonia; congestion of lungs rapidly supervened, and the patient seemed fast sinking. Bloodletting was tried, and relieved the embarrassed lungs and heart; but the improvement was only temporary.

Treatment of Rheumatism and Rheumatoid Arthritis.

At a meeting of the West London Medico-Chirurgical Society, held Dec. 3, 1887, Dr. Saville read a paper on the treatment of rheumatism and rheumatoid arthritis. The author took a peculiar interest in the disease, for he himself had been a martyr to it in its subacute form. He classified rheumatism into (1) acute, in which the temperature exceeded 102°; (2) the subacute, in which the temperature never reached 102°; and (3) the chronic form. He considered that the amount of fever and constitutional disturbance usually varied inversely as the age of the patient. He thought that the treatment of acute rheumatism by the salicylates of soda and potash, the best yet devised; and contrasted the old cases as described by Dr. Fuller twenty-five years ago—the majority of which lasted four or five weeks and upwards—with the experiences of the present day. The salicylate, properly used, now made the temperature go down in a few days, and in nearly every case the patient was quite cured within the month. He had seen no evidence that visceral complications were more frequent under the treatment. The failure of the drug may be due to three things: (1) Unsuitability of the cases, *e.g.*, where renal disease is present; (2) the mode of administration—large doses being requisite; and (3) errors of diagnosis—gout and septicæmia having been mistaken for rheumatism. He recommended graduated baths. In one case everything failed to relieve the pains but hypodermic injections of morphia. Dry and hot cotton-wool often gives relief. In the subacute and chronic forms he has tried many remedies, but cannot believe much in any of them. Saline purgatives and diuretics may be useful. Sometimes Scott's dressing and other applications, care in diet, avoidance of alcohol and sugar, warm clothing, a course of Turkish baths and massage—especially for muscular rheumatism, will be beneficial. Change of climate, mineral baths, and particularly pure sea air, as on a voyage, are useful by inducing metabolic change.—*Medical Press and Circular*, Dec. 14, 1887.

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EXCISION OF THE RECTUM—KRASKE'S METHOD.

At the Fourteenth Congress of the German Society of Surgeons, in 1885, Prof. Kraske, of Freiburg, proposed an ingenious method of operating for cancer of the rectum, which consists in approaching the diseased tissue, not from below but from behind, after removal of the coccyx, division of the left sacro-sciatic ligament and, if necessary, removal of part of the sacrum. Since this time, other surgeons have tested Kraske's method, and have found that it not only makes the removal of a portion of the rectum a more exact, and, in some respects, an easier operation; but also makes it possible to remove a portion much higher up than could be reached by any operation according to the older methods.

In his first description of his method, Kraske recommended, in cases in which removal of the coccyx and division of the sacro-sciatic ligament did not furnish room enough for access to a morbid growth situated high up in the rectum, that the sacrum should be chiselled away below a curved line passing from its border, at a point on a level with the third sacral foramen, to the border of the lower horn of the sacrum. Bardenheuer has proposed, as a better plan, a transverse exsection of all of the lower part of the sacrum. This plan is not only approved by Kraske, when it is absolutely necessary, but it was actually suggested by him in his first publication on this subject and has been done by him in one case. The consequences were not unfavorable in this case; but Kraske naturally and sensibly contends that such an exsection should not be regarded as preferable to removal of part of one side of the sacrum, except when the latter is insufficient for gaining access to the portion of the bowel to be removed.

In a paper in the *Berliner Klinische Wochenschrift*, Nov. 28, 1887, Kraske describes the method which, after considering the various proposals which have followed the first description of his method, he believes to be the best. This consists in placing the patient on his right side; making an incision from the middle of the sacrum to the tip of the coccyx, going down to the bone; detaching the soft parts on the left to the border of the sacrum and coccyx; division of the left sacral and coccygeal ligaments up to the level of the third sacral foramen; division of the soft parts over the coccyx to the right, and exsection of the coccyx with bone forceps. If now, when the soft parts are held apart with retractors, the portion of the rectum to be removed is accessible, its removal can be proceeded with. If it is not accessible, then the part of the sacrum indicated above may be chiselled away. If this does not furnish room enough, the sacrum may be reached at the level of the third foramen.

In regard to the actual removal of the diseased portion of the rectum, Kraske describes two methods: one proceeding from the anus, when the disease extends so low down that the lowest portion of the bowel cannot be saved; and the other following the general line of the preliminary removal of the bone, when the lowest portion of the rectum is not implicated. The limits of our space compel us to refer our readers to Kraske's

paper for the details of this part of the operation, which involve considerations which cannot be stated briefly.

Kraske urgently recommends saving the anus, with its sphincter, whenever it is possible, and suturing the upper portion of the bowel, after its resection, to the lower portion; and he has found it possible in his practice to do this successfully. In the paper to which we have referred Kraske gives an account of eight cases in which he has practiced his method, four of the patients dying soon after the operation, and four making a good recovery. In two of the latter cases the function of the anus was so good, after the wound healed, that the stools were passed in the normal way.

The opinions of Kraske appear so sound in theory, and they are so well supported by the results which he has secured, that they deserve the most careful consideration of surgeons, and we hope that they may receive such consideration, and a fair test in practice, not only in his own country, but also in ours.

OPERATION FOR ABSCESS OF THE SPLEEN.

In the *Deutsche Med. Wochenschrift*, December 22, 1887, Dr. Carl Lauenstein, of Hamburg, describes a case in which there was enlargement of the spleen, chills and fever, with pain in the region of the spleen, following an illness which had been diagnosticated as typhoid fever. After studying the symptoms carefully he came to the conclusion that there was an abscess in the spleen, and decided to operate for it. In carrying his decision into effect he first plunged an aspirator needle through the chest wall in the line of the axilla, passing through the eighth intercostal space, the pleura and the diaphragm, and into the spleen. Upon finding pus, he then—leaving the needle in place—resected a portion of the ninth rib as long as a finger. After this he proceeded to cut down upon the spleen with the thermocautery, and opened a pus cavity as large as a goose-egg. After fixing the spleen to the edges of the incision with tenacula, he washed the cavity out with a cold solution of salicylic acid, and tamponed it with iodoform gauze, and surrounded the chest with an antiseptic dressing. The subsequent history of the case was very satisfactory, the patient making a good recovery in about six weeks.

With this experience to guide him, Lauenstein has studied the literature of operations for abscess of the spleen, and has found none which is exactly like his own. Reflecting upon his operation and its results, he is disposed to attribute his success, in a large measure, to the preliminary partial emptying of the pus-cavity with the aspirator and the consequent diminution of tension in it, and to his leaving the needle in place while he completed the subsequent part of the operation. Another thing which contributed to the fortunate result in this case was the fact that the diaphragm was adherent to the wall of the chest, and was incapable of movements which might have contributed to infection of the peritoneal cavity. A practical conclusion from the features of this case is the opinion of Lauenstein that fixation of the diaphragm and basal pleuritis are not only important diagnostic signs in abscess of the spleen, but that they contribute materially to success in any operation for its relief.

This experience of Lauenstein, and the conclusions to which he has come in analyzing its details, are of more than ordinary interest for surgeons, and for physicians as well, to whom, in the first place, patients with diseases of the spleen present themselves. The operation which proved so successful in this case is not likely to be soon repeated; for such cases are fortunately very rare. But it is good to know what has been accomplished in one of them, in order that no patient may be permitted to succumb to an abscess of the spleen without duly weighing the possibilities of an operation for its relief.

LEGAL REGULATION OF THE PRACTICE OF PHARMACY.

There is, according to the *Concours Médical*, December 10, 1886, a proposed law before the Chamber of Deputies, of France, in regard to the practice of pharmacy, which has

some points of interest for physicians and pharmacists everywhere. The law makes a proper restriction of the exercise of pharmacy to those who have received a diploma of fitness. It also forbids any association between a druggist and a physician for their special profit, or for the pushing of a special preparation. It also forbids the practice of medicine and of pharmacy by the same individual, even if he has taken a diploma in both sciences. Physicians may furnish medicine in cases of emergency and urgency when the distance to the nearest pharmacy is not less than five kilometers (about three miles). A pharmacist may sell any simple or compound remedy upon demand; but he may not sell a remedy composed according to a physician's prescription, provided the prescription is so formulated that it may be understood by any pharmacist. Hospitals, and various societies and associations indicated, may have pharmacies of their own, provided they are in charge of qualified pharmacists.

Some of these provisions for the legitimate exercise of the functions of pharmacy are excellent; but we cannot see why a man who has the legal qualifications for the work of a physician and for that of a pharmacist should be forbidden to prescribe and dispense medicines. There are reasons why it is not generally advisable for a man to undertake to perform the labors of two callings, each one of which may demand so much time and skill as to preclude the possibility of attending properly to the other; but, in this country, a restriction of this sort would work hardship in many places in which the population is not large enough to support a druggist in addition to a physician.

As to the provision that a physician may dispense his medicines only in emengencies, and when the distance to the nearest pharmacy is not less than three miles, it may be said that such a proposition would not be listened to in the United States, and it is not likely to be adopted in France.

With these exceptions, we believe the provisions of the proposed French law to be wise, and worthy of imitation here. Druggists as well as doctors would, we think, be glad to have laws adopted in every State which would protect honest and competent pharmacists in the exercise of their calling, and define clearly their relations to physicians and to the community, while restraining the incompetent or unworthy from disturbing the harmonious and reciprocal working of physicians and pharmacists in their labors for the health of their fellow-men.

CIGAR-MAKING AND INSANITY.

The New York *Tribune*, January 20, 1888, states that, when Mayor Hewitt recently visited the insane asylum on Ward's Island, he was struck with the remark of Dr. Macdonald, Medical Superintendent, that cigarmakers were more largely represented among the patients than members of any other trade. On asking for the statistics of this institution, Dr. Macdonald informed him that, in the fourteen years during which he has been medical superintendent, 5733 patients have passed through the asylum. Of these there were: bakers, 79; barbers, 56; bricklayers, 31; butchers, 74; carpenters, 141; cigarmakers, 163; cooks, 52; masons, 66; painters, 126; plasterers, 17; plumbers, 37; printers, 94; shoemakers, 143; tailors, 178. Dr. Macdonald ascribes the large number of insane cigarmakers to the unhealthfulness of the surroundings under which the trade is carried on in this city, a large proportion of the cigarmakers working, cooking and sleeping in the same atmosphere in their tenement-house rooms.

On the other hand, President Bayles, of the Board of Health, finds that from 1874 to and including 1883, when the law was passed forbidding cigarmaking in tenements, the number of cases of insanity was 112, a yearly average of 11.2; and from 1884 to 1887, 51, a yearly average of 12.75. The number of insane tailors from 1874 to 1883 was 122, a yearly average of 12.2; and from 1884 to 1887, 56, a yearly average of 14. Mr. Bayles points out that the average number of cases yearly among the cigarmakers increased after tenement work was abandoned. He, therefore, does not attach much

significance to Dr. Macdonald's table. From all the information he can obtain, he sees nothing objectionable in the business of cigar-making in the tenements. He thinks tailoring in tenements much more objectionable.

In this Mr. Bayles appears to be in the right, and the statement of Dr. Macdonald seems to be an illustration of hasty generalizing from too scanty premises. When the figures for cigar-makers (163) are compared with those for tailors (178), it would appear that working on tobacco is not so dangerous as working on dry goods; and when both are compared with those for carpenters (141) and painters (126), it would appear that working in tenements is not materially more dangerous than working in the open air or where the air is as pure as falls to the lot of any mechanics.

As a matter of fact, any assumption founded upon these statistics, in regard to foul air or tobacco as influencing insanity, would not be unfavorable to either of them; and the statistics cited by the *Tribune* illustrate the trap into which one may fall who strains an argument in what may be a very good cause. Working on tobacco may be dangerous to the health; but the attempt to show that insanity can be attributed to it becomes ridiculous in the light of the statistics of the asylum at Ward's Island, if they are correctly reported by the *Tribune*.

In Austria the method of executing criminals differs from that in vogue in America; and, though apparently more horrible in its details, is more speedily effective. The condemned man is placed against a post, at the top of which is a hook and at the bottom a pulley. A rope having a loop at each end is passed around the neck of the victim; another is tied about his feet, the end being passed through the pulley. Two assistants then lift the man, by means of the rope around his neck, about six inches, and suspend him from the hook at the top of the post. At the same time the other assistants pull with great force at the rope attached to the feet. Death ensues usually instantaneously, though there is a range from one-half to two minutes in many cases.

Book Reviews.

[Any book reviewed in these columns may be obtained, upon receipt of price, from the office of the Reporter.]

CHEMICAL ANALYSIS OF HEALTHY AND DISEASED URINE, QUALITATIVE AND QUANTITATIVE. By T. C. Van Nüys, Professor of Chemistry, Indiana University. With 39 wood engravings. Large 8vo, pp. 187. Philadelphia: P. Blakiston, Son & Co., 1888. Price, $2.00.

In this manual, simple qualitative tests for analysis of the urine are given in full, and the rationale of chemical processes is fully explained, while to meet the requirements of students somewhat familiar with laboratory work, nearly all the methods employed in quantitative estimations are given in full; especially is this true in regard to processes peculiar to work in physiological chemistry. Five chapters are devoted to the Physical and Chemical Properties of Constituents of the Urine; one to the Examination of the Urine and Sediments; and one to the consideration of Concretions and Stones. The rest of the book is devoted to quantitative analysis.

The whole presents an admirable treatise on the subject of the examination of the urine, especially adapted to use in chemical laboratories, and suitable for men who wish to conduct such examinations in a strictly scientific way. It treats the subject in an exhaustive manner, and leaves nothing to be desired in the way of completeness.

If we were to criticise this work, it would be only from the standpoint of the average medical man, who would miss in it those practical applications of the information acquired in the laboratory, which are so great a help to the practitioner, as compared with the laboratory student. Most of the readers of the Reporter, we feel sure, would like to have the weights and measures which are given in the figures of the metric system, given also in English equivalents, or at least to have a comparative table of these measures embodied in the book. Such details are not needed by those who are daily engaged in the study of chemical problems; but most medical men cannot well get along without them.

With this exception, we find nothing to complain of in this book, which is clearly written, handsomely printed, and admirably illustrated.

SIMILIA SIMILIBUS CURANTUR? By Charles S. Mack, M.D. 8vo, pp. 31. Boston and Providence: Otis Clapp & Son, 1888. Price, 40 cents.

This little book is written by one who throughout it manifests a spirit so temperate and fair, that what he says merits very careful consideration. He is not a headstrong advocate of homœopathy; but he inclines to the belief that the application of medicines to the cure of disease may be guided by what is known as the law of similars. It is with some regret that we observe—after an admirable exordium—that the argument of this book is made in a vicious circle, and that its conclusion—moderate as this is—is not warranted by what precedes it. We have not space in which to expose what appears to us to be the fallacies of Dr. Mack's reasoning; but we must confess some disappointment that one who seems in many respects so well qualified to defend what he believes should not make out a better case for a belief which has always appeared to us to be illogical, but which we have no disposition to dismiss with a sneer.

After all has been said, we think no "law" of therapeutics can be stated which will bear close scrutiny; and that nothing better has ever been proposed for our guidance in the choice of remedies than the good old rule of experience—empiricism, in fact. So far, the pursuit of a "law" of therapeutics has been but a groping in the dark for most seekers after such a light, and a persistent following of an *ignis fatuus* for those who think they have found it.

Pamphlet Notices.

Foot and Mouth Disease as it Affects Man and Animals, and its Relation to Human Scarlatina as a Prophylactic, etc. By J. W. Stickler, M.S., M.D., Orange, N. J. From the *Medical Record*, Dec. 10, 1887. 31 pp.

Syphilis of the Endometrium. By T. A. Ashby, M.D., Baltimore, Md. From the *Maryland Medical Journal*. 16 pp.

Footprints of a Profession. By Horatio C. Meriam, D.M.D., Salem, Mass. From the *Archives of Dentistry*, Nov. and Dec., 1887. 21 pp.

Miscellaneous Reprints. By James Craig, M.D., Jersey City, N. J. 31 pp.

The Eye of the Adult Imbecile. By Charles A. Oliver, M.D., Philadelphia. From the *Medical and Surgical Reporter*, Sept. 17, 1887. 4 pp.

Traumatic Hæmatoma of the Larynx. By J. W. Gleitsmann, M.D., New York. From the *Medical Record*, Oct. 29, 1887.

Hypertrophy of the Tonsil of the Tongue. By J. W. Gleitsmann, M.D., New York. From the *Medical Record*, Dec. 17, 1877. 11 pp.

A Study of the Causes and Treatment of Uterine Displacements. By Thomas Addis Emmet, M.D, New York. From Volume xii, *Gynecological Transactions*, 1887. 14 pp.

—Dr. Stickler's paper deals with a subject of the greatest interest and importance. It contains an admirable description of foot and mouth disease in human beings and in the lower animals of the equine and bovine species, and a very interesting study of its relation to scarlet fever. The chief interest and value of the paper lie in his study of the relation of this disease to scarlatina. The conclusion to which he comes, and which he states with praiseworthy reserve, is that foot and mouth disease and scarlet fever are so related that the inoculation of human beings with the virus of mild aphthous fever in cattle may serve as a prophylactic against scarlet fever. This conclusion and Dr. Stickler's reasons for it may well be recommended to the consideration of our readers, who will find food for much thought in his interesting paper, to which we have already referred in an editorial in the Reporter for Feb. 4, 1888.

—In this pamphlet, Dr. Ashby gives the history of two cases in which miscarriage attributed to syphilis was followed by prolonged and stubborn sub-involution of the womb, and metrorrhagia. These he thinks were also attributable to syphilis. He does not assert this dogmatically; but says he has never seen any cases so difficult to manage, and can find no explanation of the fact more reasonable than the one he proposes. Other observers may have had similar experiences, to which this explanation would not apply; but Dr. Ashby's paper deserves consideration and may throw an important light upon an obscure subject.

—Dr. Meriam is a dentist who was graduated at the Harvard University Dental School, and who thinks dentists should be more than mere artisans; and he endeavors in this pamphlet, which contains an address he delivered before the Maine Dental Society, at its 22d annual meeting, in July, 1887, to impress his fellow-practitioners with the importance of observing a system of ethics like that established for the medical profession. He is especially opposed to the practice of patenting instruments or appliances, and of permitting what should be the common property of all who are engaged in the healing art to come under the exclusive control of manufacturing firms. These views, which must commend themselves to the judgment and sentiment of those who regard dentistry as a profession, he supports with argument and pleasantry, which make his address as entertaining as it is instructive.

—Dr. Craig's pamphlet contains a variety of short communications on medical subjects, several of which have appeared in the Reporter. One of the most interesting of these concerns a case of precocious menstruation. The subject was a child who began to menstruate when only four years of age, and continued to menstruate regularly until she was ten years old, when she ceased menstruating until she was fourteen years old, and then began again.

Another communication brings forward a claim for priority in the use of an elastic rubber band for ligating the umbilical cord, which the author recommended before the Medical Society of New Jersey in 1870.

—Dr. Oliver's short paper gives the results of the examination of the eyes of twenty young adult imbeciles. His conclusion is that the eyes of such persons show the effect of intellectual hebetude in the absence of changes frequently found in those who use the eyes constantly.

—Dr. Gleitsmann's paper contains an account of the case of a man who had a hæmatoma of the larynx as a consequence of a blow upon it with the fist of an assailant. In addition to the interest attaching to this case in connection with the general subject of laryngology, it is curious to note that the blow caused temporary insensibility, confirming the recent experimental demonstration of Brown-Séquard that such a result may follow such a cause.

—Some of our readers may be surprised at the term "tonsil of the tongue," as the word "tonsil" is usually applied to what anatomists call the "faucial tonsil;" and they will be interested to learn that aggregations of glandular tissue exist at the base of the tongue, which are but part of a ring of glandular tissue surrounding the opening of the mouth into the pharynx. These masses may become hypertrophied, just as what are usually known as the tonsils do, and when this happens they are to be treated by reduction or destruction of the redundant tissue. For the details of this treatment we must refer our readers to Dr. Gleitsmann's interesting and instructive paper.

—Dr. Emmet's paper ought to be read by every man who wishes to treat displacements of the uterus rationally. His large experience gives great weight

to what he says, and those who have treated cases of the kind he discusses must share, to a certain extent at least, his strong objection to the indiscriminate use of pessaries. He sees plainly that it will be hard to wean men from a practice which has the sanction of so much authority and experience, but he brings forward reasons for its restriction which appeal strongly to the judgment, and which ought to be weighed most carefully by those least inclined to accept them.

Literary Notes and Queries.

[In this column the Reporter will publish short items of literary interest and questions addressed to this Journal or its readers, and answers to them, in regard to any literary matters: books, authors, places and prices of publications, etc.]

—The *Caledonia Springs Sanitarian*, published at Caledonia Springs, Ontario, once a month, four pages, quarto, price ten cents a year, is the lowest priced semi-medical periodical we have seen yet. Its appreciation of the Reporter is seen in the fact that it looks to this journal for assistance in editing it. We observe, for example, in Vol. II, No. 2, January, 1888, one of our recent editorials on "Some Points in the Care of Children;" but we are pained to observe that the printer has cut out the reference to the source from which it was taken, which we feel sure the editor of the *Caledonia Springs Sanitarian* must have been careful to put in.

—The *Cyclopedia of American Contemporary Biography*, "from Abbe to Anderson," is received from John B. Alden, New York. It includes notices of men and women of the United States, prominent in the life of to-day. It is to be issued in small 8vo volumes of about 550 pages each, brevier type, including numerous portraits, and is to be revised and re-issued as often as annually. Volumes bound in fine cloth, price $1.00, postage 12 cents. The specimen we have received is interesting, and promises well for the whole work. We remark the absence of the names of a number of distinguished medical men in this city, which ought to have been included in a work making any pretension to completeness; but, as far as it goes, the list is useful.

—The attention of persons interested in historical or scientific investigations, or in the making of books of substantial character, is invited to the proposals of *The Editorial Research Company*, of Philadelphia, which is composed of persons who have had many years' editorial experience, and who are convinced of the need of such an agency as they have established. This company offers its assistance to persons engaged in literary work, in making researches, gathering statistics, making transcripts or translations, correcting manuscripts, and preparing indexes or reviews. Persons desiring further information as to the purposes of the company may address *J. P. Lamberton, Secretary*, 721 South Sixteenth street, Philadelphia.

—The J. B. Lippincott Company announces the intended publication of a *Cyclopædia of Diseases of Children*, to be edited by John M. Keating, M.D., of Philadelphia. The list of contributors, who have agreed to share in the preparation of this work, includes the names of a large number of well known writers in this country and in England, and justifies the expectation that it will be a work of very great value.

Correspondence.

Sudden Death After Typhoid Fever.

Editor Med. and Surg. Reporter:

Sir:—On January 11, 1888, I was called to see a young man, 17 years old, who was suffering with an attack of typhoid fever. I attended him regularly for twenty-four days, when he died suddenly and unexpectedly, having presented no unfavorable symptoms until within a few hours before his death. At the beginning of his illness his temperature rose gradually until, on the eighth day of the disease, it was 103°. After this it fell gradually until, on the twenty-fourth day, it was 102½°. At this time his tongue and the surface of his body were moist, and his pulse was about 90–95, and full and strong. He had some headache during the first few days, as is usual in typhoid fever, but was perfectly rational up to the time of his death. He had no diarrhœa at any time; neither was he constipated to any marked degree. Castor oil was administered two or three times with gently purgative effect. His bowels moved three days before his death. He had no trouble, which was discoverable, with his urinary organs, his urine being voided freely and in quite sufficient quantity. He never had any extensive tympanites, or excessive tenderness over the bowels, but was troubled somewhat more than is common with pain, though this was generally controlled with warm fomentations. Opiates were resorted to only a few times. He had no trouble with his lungs, except a very slight bronchitis, which was not as marked as is usual in this disease. His tongue was heavily coated for the first ten days, when it began to clean off. The only thing in its appearance, which I did not like, was the fact that the papillæ seemed to be rather prominent, and that the color was a slight shade redder than is usual in mild cases. The surface never became very dry. He took milk every day in sufficient quantities. In fact, he progressed favorably up to the twenty-fourth day, at noon, when I visited him.

I had given a favorable prognosis all along, and could not see anything in his case which should cause me to do otherwise. But at about 11 or 12 o'clock at night, he began to be restless and short of breath, while his pulse became quick, and remained so all night. The next morning (the twenty-fifth day), at 8 o'clock, I was called to see him, and to my great astonishment I found him with a pulse of 150, the first sound of the heart inaudible, with great distress in his breathing, a very

anxious expression, and an appearance of being in pain. When asked if he were suffering pain, he said: "No, not of any consequence." I at once recognized his great danger; but was at a loss to account for it. My first impression was that perforation of the bowels had taken place. But finding no vomiting, no more tympanites, no more pain, no more fever, and the patient able to move himself without pain, and other symptoms of perforation being absent, I concluded that it must be a case of sudden heart failure, and so expressed myself. As I have already said, he was never irrational, even to the last.

My experience with typhoid fever dates back nine years, and I have treated cases every year; but this case was different from any I have ever seen. I would be pleased to have an expression from you, or from any of your readers, as to the immediate cause of death.

Yours truly,

S. M. Hunter, M.D.

Hope, Kansas.
February 1, 1888.

[The facts stated in this letter do not warrant any positive expression of opinion; but the explanation offered by Dr. Hunter, as to the *immediate* cause of death, seems to be entirely rational.—Editor of Reporter.]

Sulphate of Magnesia for Warts.

Editor Med. and Surg. Reporter:

Sir:—*Apropos* of recent statements as to the efficacy of sulphate of magnesia in the treatment of warts, I would like to mention the following case which recently came under my notice: A man consulted me respecting a growth of vegetations surrounding the glans penis, forming a huge mass, almost as large as a hen's egg. I prescribed the use of a powder of equal parts of salicylic acid, calomel and oleate of zinc, to be renewed night and morning. The case improved slowly, too slowly for the patient's satisfaction. I then ordered one grain of sulphate of magnesia every hour, in solution, in addition to the application of the powder already mentioned. The growths now commenced to disappear rapidly, and in less than three weeks there was not a vestige of them left. The patient states that they mysteriously "melted away." He used the magnesia regularly, every hour of the day for the first week, but became more careless for the rest of the time. Yours truly,

Louis Lewis, M.D.

800 Corinthian Avenue, Philadelphia.
Feb. 4, 1888.

Correction.

Editor Med. and Surg. Reporter:

Sir:—In my article on *Diphtheria, January 28, 1888*, page 100, the direction for gargle should read: "*Gargle well every two hours,* or *ten minutes each time before taking the medicine.*" The direction in the second spray should read: "*Spray each time before giving the medicine, and apply a cloth dipped in cold vinegar,* not too wet, to the neck." Further down read: "*Elix. phosphate iron quinia and strychnia with liquor potassæ arsenitis.*" In the last formula read: "*I order syr. ferri iodidi and liquor potassæ arsenitis to be taken after meals.*"

I think a great deal of all arsenical preparations in cases of debility, as well as in all chronic affections.

Yours truly, J. Pirnat.

Evansville, Ind.
Feb. 2, 1888.

Koumiss and Lupulin.

Editor Med. and Surg. Reporter:

Sir:—In the present volume of the Reporter, page 125, you copied from the *National Druggist* directions for making koumiss. I would suggest the addition of one teaspoonful of *lupulin.* I have been accustomed to make the addition in several of those fermentative mixtures where there is considerable nervousness of the patient. It will be found soothing and exhilarating.

John M. Currier, M.D.

Newport, Vt.
Feb. 6, 1888.

Masturbation in Women and Girls.

Editor Med. and Surg. Reporter:

Sir:—I was glad to see the article in your columns entitled "Masturbation among Women and Girls." This is a delicate subject to treat, but it surely comes within the province of a medical journal. I believe that the vice to which you allude is not so common as many people suppose. At the same time, its frequency in ancient and modern times among women of indolent, luxurious and voluptuous habits is unquestioned. Here, heredity, high living, and artificial and precocious stimulation of the sexual appetite are, as you have intimated, powerful factors in bringing about the practice of this vice. It is hard to believe that the "gentler," "purer" sex can become so depraved; but it is not to be expected that the daughters will be much more virtuous than their fathers, and shameless women are not a rare phenomena even

in this Christian land. You speak of the preponderant influence of the sexual passion in the thoughts, imaginations and lives of multitudes—a fact for proof of which your readers will not have to go far. As for the allusion to the popularity of certain filthy French novels, it is gratifying to be able to chronicle the fact that the worst kind of French romances have not been reproduced, and cannot be reproduced in this country or in England.

I have personally seen comparatively little evidence of masturbation, though occasional instances are constantly coming under my observation. I fancy that most physicians hesitate, like myself, to interrogate their female patients with regard to these practices, though they may often have reason to suspect that such practices exist. Glaring instances will, however, now and then present themselves where complete physical and moral ruin has resulted from the unnatural indulgence. One such instance I saw some years ago, in which the beginning of the vicious habit could be clearly traced to the manipulations of a servant girl. Another girl, 13 years old, the daughter of a clergyman, seemed to have contracted the habit from "pure cussedness," and was one of the most remarkable instances of "innate depravity" that I have ever seen. In her case the habit was most inveterate, beginning at the age of six years; and no amount of moral suasion or correction, and no punishment availed to stop the pernicious habit altogether. Even when this girl was put in a straight-jacket and watched day and night, she found some means of exciting the sexual orgasm, and bringing about the abominable gratification. For aught I know, this patient, who is now grown to womanhood, is in daily practice of the habit. The mind has been enfeebled and the body dwarfed—in fact, this unfortunate being is a perfect nonentity as far as concerns her relations to her family and to society.

Another young girl, 7 years old, a patient of Dr. Healey, was broken down physically and mentally by the vice, and is to-day an inmate of the insane asylum at Danvers, Mass. Dr. Healey, moreover, tells me that he has at the present time under his care a female infant, only 2 years of age, who is a confirmed masturbator.

Such instances might be multiplied from the experience of many of your readers. The inveterate female masturbator is generally a hopeless case. Much can doubtless be done by every intelligent physician in inculcating among his patrons a knowledge of the existence of the vice and its dangers, and insisting upon the proper hygenic means of prevention, so that no undue awakening may be given to an appetite which nature intended should slumber till maturity; which even then ought to be very sparingly indulged, and by many persons, I think, never at all. It is not alone the appetite for strong drink that requires regulating, if not suppressing.

E. P. Hurd, M.D.

Newburyport, Mass.,
Feb. 6, 1888.

Notes and Comments.

Dizziness from Injuries to the Tympanum.

Dr. A. D. Williams reports in the *St. Louis Med. and Surg. Journal*, January, 1888, that a young man recently received a severe blow upon the left ear from a wagon stake, and was knocked senseless for a while. The ear bled freely at the time, and after recovering from the headache and the immediate effects of the blow, the patient found that he had difficulty in hearing with the ear which had been injured, and complained of a sense of numbness, or a "muffled feeling" therein. The history of the case showed plainly that there had been a rupture of the membrana tympani, but when Dr. Williams examined the ear, two weeks after the injury, there was no sign of a rent, the injury having healed so perfectly that he could not even discover its previous location. The patient, however, was so dizzy at the time that he could not walk straight, and staggered about like a drunken man. The cavity had evidently filled with blood at the time of the injury. He catheterized the drum, and found it very difficult to get the air into the cavity. The operation gave great relief to the patient, but it lasted for only a few minutes. While there might have been other injuries inflicted by the blow in this case, the author thinks the dizziness resulted entirely from the obstructed condition of the drum. In a recent case a similar phenomenon was observed. A young woman slipped and fell, striking the side of her head flat against the pavement. She at once noticed that her hearing was muddled, and that the ear on which she fell "felt as though it had been stuffed full of something," to quote her own words. On attempting to stand, she found herself so dizzy that she was compelled to catch hold of something to support her. Twelve hours after the injury he made an examination, and found a bloody line just behind the handle of the malleus, and running its entire length, showing that the

rupture of the membrane was an extensive one. While the ear did not bleed any externally, the cavity was most likely filled with blood. As the injury was still fresh, and the rupture was nicely coapted but not yet healed, he thought it best not to interfere at the time, but told the patient to return later, which she has not yet done. The cases are given to illustrate the point which the author has made before, that great dizziness frequently results from the filling up of the drum cavities, and that, in fact, very grave brain symptoms are frequently traceable to this cause, especially in childhood.

Laparotomy for Incised Wound of the Stomach; Recovery.

Dr. J. A. Black, M.D., reports the following case in *Daniel's Texas Medical Journal*, December, 1887: William Edwards, 17 years old, was stabbed, while attending a country dance, on July 20, 1887, at 9 o'clock P.M. The long blade of a large pocket knife entered the abdomen at the left side, immediately below the lower margin of the ribs, about five inches from the median line, making an external wound two inches long, which extended toward the median line, and parallel with the margin of the ribs. From this wound undigested food and blood escaped.

On July 21, at 9 o'clock A.M., twelve hours from the time of the injury, Dr. Black saw the patient for the first time. He had tossed about all night in great pain, and without medical attention. He was given anodynes and placed in a position which favored the escape of the food and blood until assistance could arrive. Four hours later, Dr. Black and Dr. T. J. Bennett, of Austin, proceeded to operate by enlarging the original cut in the direction of the median line. First an incision about two inches in length was made, which, proving to be inadequate, a further incision was carried to the median line, making a total external opening of five and a half inches transversely across the abdomen, terminating just below the xyphoid cartilage. Several large fish bones, some of them over an inch in length, and a quarter of an inch in diameter, together with a quantity of undigested food, and some blood, were found lying on the great omentum and intestines, and were removed. The small intestines, as well as the transverse and a portion of the descending colon, were pulled outside, laid upon aseptic towels, and searched for wounds, but none were found. The investigation was extended above the line of incision, when it was found that the blade had passed through the great omentum and entered the stomach near the center of the great curvature, making a wound about one and a half inches in length. The stomach was then drawn outside, and two interrupted and two continuous sutures, making four in all, were made in the wound. Fine iron-dyed silk was used to close the wound. Catgut was thought of, but it was feared that the gastric juices would digest the sutures before union could take place. As the stomach was pulled outside vomiting took place, and some depression was noticeable for a short time. It is worthy of note, that, while vomiting was taking place, the stomach was held in the hand of the operator, and the firm and uniform contractions, which the muscular structure of the stomach would indicate should take place in vomiting, were actually felt. Absorbent cotton was used instead of sponges. The viscera were carefully cleansed and returned, and the abdominal cavity mopped out with the cotton. No irrigation was employed. The external wound was then closed by eight interrupted sutures of strong iron-dyed silk, the peritoneum being included in each one. Space was left for the escape of pus, in case any should form. Iodoform and carbolated absorbent cotton, confined by a broad bandage, tightly applied, constituted the dressing. The patient was placed on his back, with the shoulders elevated, and a roll of quilt placed under the knees. Anodyne and nutrient enemas were ordered, and only ice water was allowed to enter the stomach. The position of the patient, and attention to the bladder, etc., constituted the chief directions given the nurse after operation. Although the external wound suppurated and the patient was subsequently attacked with colliquative diarrhœa, so severe as to threaten life, he ultimately made a complete recovery.

An English View of Homœopathy.

The *British Medical Journal*, referring to some recent statements by Lord Grimthorpe, remarks that the latter has a boisterous rhetoric, and wields the literary truncheon with quite a special gusto. He is not infrequently, and always noisily, at fault; and rarely more so than in his present assault on medical men who decline professional association with homœopaths. In the main he strikes wide of the mark. No one pretends that "homœopathic" practice is illegal, any more than "magnetic" practice, or "faith-healing." But homœopathy, in the opinion of medical men generally, is either a nullity or a fraud. Under this conviction, which is shared by

the wisest and the best among us, medical men habitually decline to consult or to act professionally in concert with "homœopaths." This Lord Grimthorpe decribes as "boycotting." If so, it is only a new name for a very old practice, which the bar, equally with the profession of medicine, have found necessary to maintain a due standard of professional sense and morality. If a barrister were to see clients and receive instructions without the intervention of a solicitor (a purely artificial restriction), what course would his professional fellows and the class of solicitors adopt? The professional etiquette and the rules of the practice at the bar are in many ways more restrictive than those of the profession of medicine and more severely enforced. Everyone who pleases is free to practice "homœopathy," or any other "pathy" he can practice in this country with or without education, and with or without a degree. A penalty is incurred only on the false assumption of a title. It is open to Lord Grimthorpe or to anyone else to consult him or to build hospitals for him to practice in. But it is certainly not in his power or his right to constrain the great body of highly educated men who regard such practices as frauds, or nullities, or public dangers, to enter into or to countenance any professional alliance with their professors. His violence, his threats, and his rhetoric appear, therefore, to be alike thrown away.

Treatment of Carotid Hemorrhage.

Mr. Frederick Treves, surgeon to the London Hospital, in a communication upon the treatment of carotid hemorrhage to the *Lancet*, Jan. 21, 1888, remarks that he thinks the ligature of main arteries for the arrest of bleeding in distant parts is often somewhat blindly advised, and possibly too frequently carried out. He reports four cases in which, instead of tying the artery, he passed a ligature around the common carotid, and kept up traction upon the ligature for some time after the hemorrhage ceased. The method proved satisfactory in every case. One patient, a child three years old, died six days after the operation, but death was the result of exhaustion from previous hemorrhage. The hemorrhage was in all four cases of a grave character, and such as, in three of the instances, one who adhered to the usual surgical practice would have controlled by means of ligature of the common or external carotid. By the exercise of careful antiseptic precautions, he thinks that no very serious risks attend the operation itself.

The Medical Societies of Brooklyn.

There are no less than six different societies in Brooklyn organized and maintained for the advancement of medical science. Some of these bear in their titles the name of the county rather than that of the city; but their membership is made up mainly of residents of Brooklyn, which city is in fact the greater part of the County of Kings in respect to population. These societies are: the Medical Society of the County of Kings, the Brooklyn Pathological Society, the Medical Microscopical Society of the City of Brooklyn, the Brooklyn Surgical Society, the Kings County Pharmaceutical Society, and the Brooklyn Dental Society.—*Brooklyn Medical Journal*, January, 1888.

A Doctor Classed as a Commercial Traveller.

The Paris correspondent of the *New York Medical Journal*, February 4, 1888, says: Another case of professional interest was decided by the Paris tribunals lately. A doctor had agreed with a druggist to write articles recommending a certain chemical product manufactured by the druggist, and also to deliver lectures in regard to the product, recommending it, in fact, by all possible means to his professional brethren and the public. In consideration of these services the druggist agreed to pay the doctor 4000 francs a year and certain expenses. Afterward the doctor refused to continue the work for the druggist, who at once sued him. The doctor's lawyer maintained that he could not be compelled to carry out such a contract, as he was not a man of business. The tribunal, however, decided that, as the doctor had agreed to do work such as an ordinary commercial traveller did, he was responsible. It was added that a physician should only advise any preparation which he knew to be useful in the ordinary way of giving advice at his office or at a patient's house, and not by advertisements; and that he should not receive any payment for such advice, beyond his usual professional fees, under pain of being ranged with the regular mercantile traveller. This would not be a bad judgment on those who recommend certain preparations, for a consideration, in other countries!

Successful Excision of a Tumor of the Spinal Cord.

At a meeting of the Royal Medical and Chirurgical Society on Tuesday, January 24, 1888, Mr. Victor Horsley presented the patient from whom he had removed a myxoma

of the spinal cord on June 9, 1887 (see REPORTER, July 23, p. 126, 1887). It is interesting to learn that, following the operation, the pain from which the patient had suffered acutely was for a time slightly relieved, but again and again recurred with great severity, and the power of motion was only slowly and intermittently regained during the first three or four weeks. Pressure over the wound was obtained by a pad and strong jacket; the local pain gradually diminished; the motor power gradually returned to the lower parts; and, after seven months, the use of the lower limbs, though a little stiff, had become almost natural, and the remains of the laminæ had come so near together in the well healed cicatrix that any further external support seemed unnecessary.

Charges against an Eclectic Physician.

A despatch from Chicago to the New York *World*, January 20, says: A. B. Pullman, brother of George M. Pullman, of the Pullman Palace Car Company, has begun a suit for $25,000 damages, charging criminal malpractice against Dr. Pingree, an eye and ear specialist, for whom it is understood a warrant is out. Mr. Pullman's wife has had a cancer on the nose for about ten years, and it has eaten away the greater part of that organ, greatly disfiguring her face and endangering her life. Dr. Pingree has been treating it for the last two years, and Mr. Pullman alleges that he used violent remedies which made the cancer worse. Dr. Pingree was graduated at the Bennett College of Eclectic Medicine and Surgery, Chicago, in 1880.

Prescription for Chronic Cystitis.

Prof. Brinton recommends (*College and Clinical Record*, January, 1888), for chronic cystitis:

℞ Uvæ ursæ..... ℥ij
Lupulini..... gr. xv
Aquæ bullient..... f℥vj
Misce. Ft. infus. et adde
Sodii bicarb..... ℥ss
Tinct. opii camph..... f℥j
Aquæ..... q. s. ad f℥viij.
M. Sig.—Tablespoonful four times a day.

Ointment in Small-pox.

The following ointment is said to act as an anæsthetic and antiseptic, and to prevent pitting:

℞ Pulv. iodoformi..... ℥ss
Pulv. camphoræ..... ℥i
Vaselini puri..... ℥j
Misce. Ft. ung. Sig.—Apply by gentle inunction to the affected parts of the skin.

NEWS.

—Dr. Harvey Shoemaker and Dr. Thompson S. Westcott have been elected resident physicians of the Pennsylvania Hospital in its Insane Department.

—Recent reports from San Remo regarding the condition of the Crown Prince of Germany are rather unfavorable, and it has been found necessary to perform tracheotomy earlier than was at first expected, in order to relieve the difficulty in breathing.

—It is reported from Springfield, Illinois, that scarlet fever is prevailing in Pana, on the Ohio and Mississippi Railroad, to such an extent that the public schools have been closed. There have been two deaths, and fifteen cases of the disease were reported on February 4.

—The committee of the New York Academy of Medicine, appointed to coöperate with the Health Board of that city, has made its report to Mayor Hewitt. The committee consisted of Drs. C. R. Agnew, E. C. Janeway, Stephen Smith, A. Jacobi, T. Mitchell Prudden, H. M. Briggs, and Richard H. Derby. The Mayor requested the committee to make an early examination of the Quarantine establishment, point out its defects and requirements, in order that it may be brought up to the highest ideal standard of modern scientific and medical knowledge, to estimate the sum required to be appropriated by the state in order to complete the necessary improvements, and to suggest whether New York should provide any further temporary hospitals in case there should be an outbreak of cholera in the city.

The character of the report is such as to excite concern in New York in reference to the miserable condition of things at Quarantine. The *Tribune* says, Jan. 3, 1888, "So long as it continues the entire country is confronted with an appalling danger. When such an able committee as that which presents this report unites in confirming in detail all that the public has long feared with regard to Hoffman Island, it is high time for action. The medical committee has performed its work with commendable completeness. It shows what must be done and just how to do it. The Legislature will doubtless be its own best judge of how the suggested commission should be composed, but the evidence now before it of the necessity of providing the island with adequate facilities for holding imported contagion in check is too abundant and too serious to be disregarded."

HUMOR.

A GEORGIA FARMER made one hunderd dollars off an acre planted in watermelons, and a neighboring doctor made two hundred dollars off the same acre.

FAITH CURE AND PHYSIC.—Gus De Smith—"I've been reading about a remarkable faith cure." Gilhooly—"I don't believe in it. Physic beats the faith cure every time." Gus De Smith—"Well, it ought to; it has the inside track."

A FORMER PATIENT met a doctor who practiced at a mineral spring, in Germany, and said to him: "Why, doctor, if you are a physician to the springs, how comes it that I find you in Frankfort?" "Well," replied the doctor, "you see I am a physician to the springs in summer; in winter I collect patients."

LADY (handing prescription ordering pil. aloes et ferri gr. vj; mitte iv): "Make up this prescription, please. How much will they be?"

Chemist: "Sixpence."

Lady (astonished): "Oh! dear, no! they will be more than that; *that is one of Sir William Gull's prescriptions.—Chemist and Druggist.*

A YOUNG PHYSICIAN, who has just established himself, and has very little practice, is noted for his braggadocio. One of the older physicians, meeting him on the street yesterday, asked him how he was coming on. "I've got more than I can attend to," was the boastful reply; "I had to get out of my bed five times last night." "Why don't you buy some insect powder?" asked the old doctor.

NEW USE FOR ICE.—"I'm going to Maine after a consignment of ice for consumption in Washington," said an Avenue dealer to a new reporter nosing around for an item.

"Indeed," exclaimed the reporter, pulling his note-book, "that's something new. I didn't know before that ice was a remedy for consumption."

The city editor saved the reputation of the paper.—*Washington Critic.*

OBITUARY.

E. MILES WILLETT, M.D.

Dr. E. Miles Willett, Professor of Clinical Medicine in the Memphis Hospital Medical College, and Supreme Medical Examiner, Catholic Knights of America, died suddenly on February 6, 1888, at his residence, in Memphis, Tenn. He was graduated at Jefferson Medical College in 1855.

GEORGE W. TRYON, JR.

Mr. George W. Tryon, Jr., who died on February 5, 1888, at the age of 50 years, was the most eminent conchologist in this country, if not in the world, and a highly valued member of the Academy of Natural Sciences.

WILLIAM ASHMEAD, M.D.

Dr. William Ashmead died at his home in Germantown on February 2, 1888, aged 87 years. He had been a practicing physician in Philadelphia for upwards of fifty years; but, about ten years ago, he withdrew from active service and retired to his home in Germantown. He was connected with the State and County medical societies, and took considerable interest in other professional and scientific associations. One of his most recent acts of benevolence was the contribution of $3000 to the Wills Eye Hospital.

E. J. SNITCHER, M.D.

Dr. E. J. Snitcher, a well-known physician of Camden, N. J., died on February 6, 1888, in his 39th year. He commenced the study of medicine in the office of Dr. N. S. Davis, of Chicago, in 1872. In March, 1874, he was graduated from the Chicago Medical College, and subsequently removed to Camden. In 1876 he became a member of the Camden County and the New Jersey State Medical Societies. He was a director of the Camden City Dispensary until impaired health made it necessary for him to retire.

E. J. ENGLEMAN, M.D.

Dr. Edgar J. Engleman, a well-known physician, died on Monday, February 6, 1888, at his residence in Philadelphia, at the age of 74 years. He was graduated at the Jefferson Medical College over fifty years ago, and practiced his profession for a number of years in the West. Until recently, he lived at No. 701 Pine Street.

Official List of Changes in the Stations and Duties of Officers serving in the Medical Department, U. S. Army, from Feb. 5, 1888, to Feb. 11, 1888:

Major John H. Janeway, Surgeon; Capt. William E. Hopkins, Assistant Surgeon, detailed as members of the Army Retiring Board in San Francisco, Cal.; convened by S. O. 168, A. G. O., July 22, 1886. S. O. 28, A. G. O., Feb. 4, 1888.

First Lieutenant Nathan S. Jarvis, Assistant Surgeon, ordered from Fort Lewis, Col., to Fort Leavenworth, Kansas. S. O. 30, A. G. O., Feb. 7, 1888.

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Clinical Lecture.

OSSIFLUENT ABSCESS; OSTEITIS OF THE PELVIS.

BY PROFESSOR TERRILLON,
SURGEON TO THE SALPETRIERE, PARIS, FRANCE.

(Translated by E. P. Hurd, M.D.)

Gentlemen:—I shall take as the subject of to-day's lecture two patients, one of whom is a youth 16 years of age, the other a woman 29 years old. The first patient has been suffering from slight pains and soreness in the anal region; then a well-defined swelling appeared there, which had attained the size of a large chestnut, when it was recognized as an abscess and opened by a physician who was called in. The incision did not heal, and there remained a fistula which proved utterly rebellious to treatment. This fistula remains to-day, and gives vent to considerable clear serous pus, mixed here and there with a few drops of blood. By the side of this fistulous orifice, you may see a little purplish swelling, which projects somewhat above the surface, is indurated, and presents a characteristic to which I invite your attention, namely, that it rests on a base which is hard and painful to pressure. By the fistula neither gas nor stercoraceous matters find vent, and though one would be inclined at first to regard it as a fistula in ano, he is soon convinced of his mistake. Indeed, if you explore the tract with a probe, you see at once that the instrument takes a direction away from the rectum, which shows that the disease is not a simple anal fistula; the probe, in fact, penetrates two inches at least in two different directions, but always externally, with an inclination towards the ischium. This exploration, moreover, enables you to determine the existence of profound detachments of tissue.

If at the same time that you make this examination you introduce the finger into the rectum, you can easily ascertain that it is separated from the probe by quite a considerable thickness of tissue, which seems hard, especially on the side toward the ischium, and this materially helps the diagnosis. Here, as you should always do when it is possible, you ought to compare the diseased with the well side. The pulp of the finger turned toward the internal aspect of the right ischium finds nothing abnormal; the suppleness of the tissues enables you to feel the hardness of the bone; the same exploration, on the contrary, when made on the left side, where the fistula is seated, reveals the presence of an induration which is precisely the same as that indicated before by the probe, and which gives a very different sensation from that given by the healthy bone on the other side. If you press upon this induration the patient feels pain; there is, then, disease of some kind at this point, and it is here that we are to search for the origin of the fistula. From all these signs we are warranted in affirming the existence in this case of an irregular focus of inflammation, one prolongation of which occasions the cutaneous induration in the neighborhood of the fistulous orifice; we have here the indication of a secondary pus burrow.

What can be the cause of this kind of fistula, unless it be a lesion of the bone? But what is the nature of this bone disease? This must be determined before a rational prognosis can be made, or a suitable treatment instituted. You are aware, gentlemen, that the question of ossifluent abscesses has become quite a question of late, by reason of recent discoveries in

pathological anatomy, which enable us to affirm their tuberculous nature, and by reason of the modifications which their treatment has undergone. What, then, is the lesion of the bone? We cannot go astray in assuming it to be tuberculous. The osseous tubercle, which is always found when it is sought for, is ordinarily developed without any traumatic cause. You see at first, under the periosteum, a mass of embryonal cells which destroy the osseous trabeculæ; then, at the end of a certain time, you are sure to find opaline granulations of tubercle in the midst of this mass. Lastly, these tubercle granula degenerate, become yellow, caseous, liquefy, and form a tuberculous abscess. The abscess, however, does not always follow the lesion, may not pass the stage of caseification, and in this case resorption is still possible. Whenever a lesion of this kind is produced in a bone, the latter institutes a sort of protective process: around the tuberculous nodule an inflammation is set up, a zone of condensing osteitis, which establishes a barrier between the healthy and the diseased parts.

But it must be admitted that oftener an abscess forms, the periosteum is elevated and ulcerates, and pus invades the neighboring cellular tissue; the abscess sac then enlarges, and soon approaches the surface. To a small osseous lesion may correspond a vast abscess, connected with the bone by a narrow neck, and containing several quarts of pus.

You have certainly seen those vast abscesses which are consecutive to Pott's disease of the spine; these are perfect types of ossifluent abscesses. We have not to do merely with the bony lesion and the pus which it secretes. This lesion is often too insignificant to explain these great collections of matter; but there exists also an anatomical reason which enables us to comprehend the often prodigious development of these abscesses. This reason is the texture of the sac which contains them, and which in these particular instances truly merits the name of *pyogenic membrane*. It is a matter of common observation that when these abscesses open the fistulous tracts, the neighboring tissue-detachments and the surface of the diseased bone are covered with fungosities; a sort of tomentous membrane fills all the cavities and secretes the pus, and this explains why these lesions so obstinately persist, despite energetic treatment. What we surgeons are most apt to see is the relics of these abscesses, as in the case of our little patient.

The anatomical constitution of this pyogenic membrane explains the prolonged suppuration. It is especially to the studies of Lannelongue, and of Koester, that we owe the knowledge we possess of this subject. This membrane is formed of three generally quite thick layers thus superposed: 1. An internal layer in relation with the pus, which is of fungous character, being constituted of fungous granulations. 2. More deeply still, a layer of gray tubercle granula. 3. A fibrous, or limiting membrane. Hence, it is easy to understand why irritant injections do not succeed in completely destroying this new formation; it is only by the red hot iron, or by curetting and scraping, carefully and thoroughly done, that we can hope to effect the disappearance of this membrane and thus obtain a cure. This method of treatment is applicable to all cold abscesses.

Those pus-burrows, those glove-finger prolongations which characterize this kind of abscess, find an explanation in pathological anatomy, for upon this membrane there are little *culs-de-sac* which seem to be the starting point of future prolongations. Hence, arises the necessity, when you curette an abscess, of taking the utmost pains not to neglect any of these *culs-de-sac*, and to scrape out all the prolongations; unless you do this you will have your work to do over again. These lesions are unquestionably of tuberculous origin; histology proves it, clinical practice confirms it, and the constant presence of the tubercle bacillus may be regarded as infallible evidence of it.

What shall be the prognosis of these abscesses? and what would become of this lesion if left to itself? It is undoubtedly true that now and then an abscess of this kind has got well of itself, especially when it originates in the walls of the pelvis; but such cures are very exceptional, and only come about after a long time. I have, however, seen a few of these abscesses get well after one or two aspirations.

In order to obtain a speedy and favorable termination, surgical intervention is required. Bear in mind that it is a bad plan to leave a patient who is suffering with ossifluent abcess too long exposed to the evils of suppuration; for, by reason of the nature of the disease, you would have reason to fear a general infection starting from this local tuberculosis, and you might ultimately see your patient carried off by pulmonary phthisis, or tuberculosis of the peritoneum. In the case of our young man, I do not think that we can look for a spontaneous cure; this hardness in proximity to the fistula,

his violaceous and indurated swelling, prove to us that the affection is far from the period of decline, and rather on the increase. Moreover, the patient is in bad condition physically, and is a fit subject for the spread of the tuberculosis, and this would be a sufficient reason why I should surgically interfere. Considering the location of the abscess, we cannot employ the antiseptic dressing in all its rigorousness; but I will perform the radical operation by means of the thermocautery, and I will cauterize deeply all parts of the fistulous tract, in order thoroughly and completely to destroy the membrane which lines it. After having previously removed all the fungosities, as soon as I shall come down upon the bone, I will make use of the curette in order to scrape away all the diseased tissue as far as the indurated zone. As there will be bleeding points in our wound, I will afterward, as a dressing, pack it with tampons of iodoform gauze.

I have just given you in connection with our young patient the history of ossifluent abscesses in general. We have in our wards a female patient whom I shall now present, who will illustrate more especially osteitis of the pelvis, and its pathogeny. This woman is now twenty-seven years of age, but it was at about the age of thirteen or fourteen years that she experienced the first symptoms of the disease which to-day brings her to our wards. At this time of life she fell, striking the region of the pelvis; the traumatism was quite slight, since, at the present time, she cannot specify exactly the point that was contused. Three months afterward, there presented itself in the right inguinal region a little indolent swelling, which became fluctuating, and burst, giving issue to a certain quantity of pus; this abscess was then transformed into a fistula which persisted for a number of months, and finally got well of itself. At the end of a certain time, as a result of too fatiguing work, this fistula broke out anew, and another one like it was produced by the same mechanism in the region of the left groin. Meanwhile the patient married, and had a child; these fistulæ continued to cause no serious harm, appearing and disappearing from time to time, but never entirely getting well. For some time past, and since the commencement of a second pregnancy which is now going on, there has been an aggravation of the local disease. Quite severe pains have been felt about the upper and posterior part of the right hip where a new abscess has formed, ending, like the previous one, in the production of a fistula. The one on the left side, which for a time was healed, has broken out anew. A probe introduced into these fistulæ penetrates to a considerable depth, but does not strike bare bone. The palpation of parts in the vicinity of these fistulæ discloses a good deal of swelling, and at the same time a fixed *point douloureux* on the right side in the neighborhood of the os pubis. The finger introduced into the vagina detects the same swelling, and elicits the same pain when high pressure is made on the lateral wall of the same side. But this is not all; if the pressure is continued for a certain time, it gives rise to the flow of a quantity of pus by the newly-formed fistula. The rectal touch does not elicit any similar symptom. The pressure of the finger on the left lateral wall of the vagina does not at first give rise to any symptom worthy of note; when, however, it is made with considerable force, it also determines a painful sensation in the region of the pubic bone of the same side.

These symptoms undoubtedly point to a lesion of the pelvis, probably of its pubic portion. We may even be sure that the pus which is formed in the diseased foci has made for itself a passage through the soft parts of the vicinity, and has finally pointed at quite a distance from its source.

Such are the lesions with which our patientis afflicted. What is the prognosis and what shall be the treatment? Such are the questions now before us. But, before taking up this part of our subject, permit me to indicate to you, in a few words, the pathogeny of this variety of osteitis, which has been for several years the subject of numerous works, of which you will find a summary in the recent excellent thesis of Gouilloux, pupil of Ollier, of the School of Lyons. The ossification of the different pieces which enter into the composition of the os innominatum takes place by two successive developmental processes. In the first period, the os innominatum is constituted by three distinct segments, corresponding to the ischium, the pubes, and the ilium, which converge toward the centre of the cotyloid cavity, and are separated from each other by connective cartilage. At about the age of ten or twelve years, this cartilage ossifies, and the bone is constituted in its essential characters. But about the age of thirteen or fourteen years, a little earlier in females than in males, there appear, at the periphery, complementary points of ossification, separated from the bone by a special connective cartilage. These are the pubic points, for the internal extremity of the pubis, the iliac points for the crest of the ilium, the ischial points for the

tuberosity of the ischium, the ischiatic points for the ischiatic spine, and lastly the posterior iliac points for the postero-superior spine of the ilium.

Now, since the spontaneous lesions of the bone habitually develop in points which border on the connective cartilage, this being the most active seat of osteogenesis, the following results are sure to happen: During the first twelve or thirteen years of life, the bone diseases of the pelvis localize themselves always at the centre of the bone—that is to say, in or around the cotyloid cavity. You know, in fact, that up to this time of life coxalgia of bony origin is very frequent, while very rare after this period. From the age of fifteen years, things take place differently. When the pelvis becomes the seat of an idiopathic osteitis, this always, or almost always, develops in the peripheral parts, in certain well-defined spots, which are none other than the points of ossification of which we have just spoken. There are, then, osteites of the internal part of the pubes, of the tuberosity of the ischium, of the crest of the ilium, of the spine of the ischium, of the posterior-superior spinous process of the ilium. Add that it is not rare in these osteites, at least at the onset, to find a sequestrum which is constituted in its totality by the osseous part, the epiphysis, not yet united to the rest of the bone. Unfortunately, matters do not always rest there. The affection does not always remain localized to the epiphysis; it may extend to the diaphysis, and to the periosteum, which covers it, so that, limited at first, it becomes general, and in time acquires a gravity which it did not have at first.

You see at once, without the necessity of my longer insisting thereon, the importance of early interference, if one would prevent the extension of the disease. A little operation performed in time often suffices to accomplish the radical cure of a lesion, which, if it goes on, cannot be benefitted by the most extensive and formidable operation. However this may be, these osteites, when once developed and left to themselves, undergo evolution in two ways. Sometimes they take on an acute march with inflammatory phenomena of considerable intensity, vast detachments of the periosteum, and grave general symptoms of a typhoid character. This train of symptoms, which is none other than that of infectious osteo-myelitis, designated under the name of *typhus of the members*, is not now under consideration; this is not in fact what our patient has been suffering from. At other times, the disease has a less rapid course and one fraught with less anxiety. The inflammatory phenomena are moderate for a long time; the lesions are localized, giving rise to pains having their principal seat at the diseased point, but likely to radiate to different parts. In a city patient, suffering from this same affection, and in whom I had to remove the spine of the ischium, the pain was felt chiefly along the course of the sciatic nerve, and that person had in fact been treated for more than a year for ordinary sciatica. The same painful irradiations may affect the crural and obturator nerves when the disease is seated in portions of the neighboring bone. At the end of a certain time, the pus, which forms in the diseased focus, tends to make its escape externally. Almost always the pointing occurs in a spot which is at considerable distance from the seat of the pus formation. We must, however, make exception in this case of the pus which comes from lesions of the crest of the ilium; this part being subcutaneous, the abscess points immediately over the spot where pus is formed.

Things are quite different when the pus comes from some of the other regions of the innominate bone. The pus has been known to open a way into the vagina, the bladder, the rectum, into the septa of the crural muscles, sometimes as much as ten or fifteen inches from its starting point. I have even seen an abscess of this kind open in the neighborhood of the popliteal space. These are facts of an uncommon character, of which, however, you must be cognizant if you would avoid gross mistakes in diagnosis.

The young girl from whom I removed the spine of the ischium, and of whom I have just spoken to you, had at the time I operated on her, a fistula in the neighborhood of the anterior superior spine of the ilium, and another in Scarpa's triangle. At three different times she has passed pus by the rectum; for six months the abscess emptied itself into the bladder. In cases like this, authorities have sometimes seen fistulæ of like nature complicated with the passage of a sequestrum into the bladder, and this sequestrum has finally become the nucleus of a veritable calculus. When the fistula is not too far away from the diseased point, and can be explored, you will sometimes find simple sequestra surrounded with fungosities. I have already spoken to you of these sequestra, and have shown you that such cases are the most favorable—sometimes so favorable that the sequestrum may be eliminated spontaneously, and the patient will get well without the necessity of surgical interference. At other times, the probe comes upon a bony surface

in continuity with the rest of the bone; this surface is bare, friable, bleeding at the least touch, and, if exposed, you observe that the diseased part extends a great distance: it has been found to occupy the half of the ilium.

The prognosis is in relation with the extent of the lesion. Benign in mild cases, since the disease may get well of itself, it is very grave and finally entails death when a great extent of the bone is diseased. It is true that, in the latter cases, the patient sometimes preserves for a long time the appearances of health. I need only refer you for proof to the patient who is the subject of my lecture. Her disease, which began about the age of fifteen years, constantly progressed for thirteen years; and, nevertheless, she married, had one child, and became again pregnant. But this favorable condition cannot last. Under the influence of the interminable suppurations to which these patients are subject, there is developed, sooner or later, a special cachexia due to exhaustion, to amyloid degenerations of the liver and kidneys, as well as blood poisoning from stagnation and absorption of pus; and, finally, the patient falls into marasmus and dies.

The treatment of these lesions is dominated by this fact, resulting from what I have just told you, that early interference is necessary, while the lesion is limited to the epiphysis, and is manifested by the presence of a sequestrum, which is the epiphysis itself. Our first patient, as I have told you, was in this condition; I removed the part of the ischium which was diseased, and doubt not that the event will prove that a radical cure was effected. It will not always be necessary to attempt at once the search for the diseased bone. You would be perfectly warranted, when in the presence of a recent abscess, in restricting your efforts at first to a simple puncture with the aspirating needle, which you may even repeat several times. I have had the opportunity of observing four patients who were plainly affected with these varieties of osteites, and who have been radically cured after four or five punctures. In two of them the lesion was seated on the rami of the pubes; in one it was in the iliac fossa; in one in the posterior-superior spine of the ilium.

This simple method of treatment, however, ought not to be continued indefinitely; and if at the end of a certain time, which should vary according to the gravity of the lesion, no amelioration is produced, you should cut down upon the seat of lesion and remove any diseased or dead parts. Once it was the custom to wait till the abscess burst of itself; it is no longer necessary to exercise this caution, now that with Lister's antiseptic dressing, we are able to insure the patient against the dangers of that septic fever which formerly was an almost certain accompaniment of the spontaneous opening of these osteopathic abscesses.

When the abscess has its origin internally in the iliac fossa, it has been proposed to attempt its exploration by trephining the iliac bone. This is an excellent means; moreover, in certain cases it is the only means which satisfies the indications of giving sufficient access to the focus of disease. I need not say that if, instead of a loose sequestrum, you should come upon a spot of carious bone without precise delimitations, you should remove all the diseased tissue. In cases of this kind, Ollier has performed ablation of portions of bone which were truly enormous, and has had only good results. You should bear in mind, furthermore, that the operation is of benefit to the patient, even when it is impossible to remove all the diseased bone. There is, in fact, always an advantage in being rid of a suppurating surface of bone of considerable dimensions, whose presence is a powerful source of enfeeblement and cachexia.

The free opening of all pus tracts and pus burrows in a downward direction, so as to facilitate the flow of pus, also renders great service to patients, even when you cannot scrape away or remove the diseased bony tissue.

It is these latter considerations which have induced me to propose interference in the case of our patient. When she shall have completed the puerperal period, I shall undertake an operation in search of diseased segments of bone, and any which may be found shall be removed as thoroughly as possible. I do not dare to hope that I shall thus succeed in wholly arresting and suppressing the disease, and thus curing the patient; but what I am sure of is that I shall notably ameliorate her condition and prolong her life, while making it much more comfortable.

—The St. Alban's Hospital, at St. Alban's, Vermont, was burned on Sunday night, January 12, and two out of eight patients were suffocated. The fire was discovered in a closet in the kitchen, and soon got beyond control. There was no male help, and no special provision had been made against fire.

COMMUNICATIONS.

FLAT ROCK AND HENDERSONVILLE, NORTH CAROLINA; AS HEALTH RESORTS.

BY ALLARD MEMMINGER, M.D.,

PROFESSOR OF CHEMISTRY AND HYGIENE IN THE STATE MEDICAL COLLEGE OF SOUTH CAROLINA, CHARLESTON, S. C.

As the influence of climate on phthisis and its allied affections just now engross so much of the attention of professional men, and especially the climate of western North Carolina, it may not be out of place to bring to the attention of health-seekers a little summer resort which is as yet unknown, but which I hope before long will be as conspicuous in the eyes of the public and those seeking a health resort as Asheville and her environs—I refer to Flat Rock, North Carolina, situated on the Asheville and Spartanburg Railroad, which can be reached from New York in twenty-seven hours, and from New Orleans in twenty-eight.

At present, Flat Rock consists of a settlement made up of many well-to-do families, who have for more than half a century been in the habit of spending the best part of the year in pleasure, recreation, and recuperative pursuits.

This place is peculiarly situated and well fitted by nature to be a health resort. The climate is mild and temperate; the soil, although unfertile, presents to the sanitarian those conditions upon which the healthfulness of a place depends—that is, comparative dryness of surface soil, great depth of the ground-water, and slight fluctuations between the ground and surface waters.

Flat Rock, North Carolina, is situated on the Asheville and Spartanburg Railroad, 2226 feet above the level of the sea, forty-nine miles from Spartanburg, South Carolina, and twenty-two miles from Asheville, North Carolina. It is surrounded by mountain ranges, which are at distances sufficient to keep off and break the cold blasts of winter, and not sufficiently near to create droughts or to change the number of sunshine hours in our short winter days. The average height of these mountains may be placed at 1000 feet, although the many peaks of these mountain chains often rear their proud and lofty heads as many more.

Two miles from this favored spot lies Hendersonville, a picturesque little village of eight hundred or more inhabitants, but which in summer time for a short while contains as many more. This town has, in my opinion, more claims to being a health resort than is generally conceded to it by the public. It is situated on the same plateau as is Flat Rock, and has a similar climate and soil, barring of course, the impurities incident to a larger population and a smaller area. Surrounding this village are the summer residences of wealthy families, which, having determined to make this part of North Carolina their summer home, have located on the boundaries of the village, so as to enjoy the advantages incident to being near a town. Taking all things into consideration the climate and soil of these two places are alike. Situated thus between mountains which are sufficiently remote not to be obstructive, Flat Rock offers to the invalid many advantages over places situated more in the heart of the mountains, and which do not offer so many facilities for excursions by foot and by carriage. The drives are good, the walks well shaded, and the roads so graded—or rather the natural grades are so moderate—that those recovering from serious attacks of illness find it no hard task to take either a morning stroll or an evening walk.

This resort, as before said, being originally planned by wealthy residents of the seaboard, has naturally partaken at all times of their refinements; and could this locality be brought more conspicuously into notice, I am quite sure that to place a large and fine hotel in this "land of the sky" would be an enterprise likely to be crowned with financial success.

Situated in the heart of this picturesque little settlement, almost on the banks and in view of one of the most beautiful of artificial lakes, stands the church, which happens to be Episcopalian, but in which all denominations meet and pour forth their humble prayers on Sunday, devoutly kneeling. Around this church stand the sentinels of the past, which show that the Angel Azrael has dealt kindly with this little flock.

The geologic formation of this place belongs to the Eozoic period, and comprises the Huronian, Labradorian and Laurentian systems; the soil is sterile and unfertile, and the drinking water is as free from impurities as the soil is free from fertilizing ingredients; the springs are bold, cold, sparkling and as clear as a crystal, and the wells which I have repeatedly seen sunk, and of which I have more frequently drunk, may be characterized as good and wholesome drinking water, free from lime and magnesia, and vieing in excellency with the springs just mentioned.

It seems to me, in view of these facts, that diseases contracted in this section can never be fairly attributed to emanations from the soil, or to the character of the water used for drinking purposes. On the contrary, in every case of typhoid fever or kindred "filth," affections, which has come under my notice, the cause has been clearly traceable either to defective drainage and a general and total disregard of sanitary laws, or else to water pollution.

If we glance a moment at the climatological conditions of this place, I think we may safely say that it is entitled to as high a place in our estimation as a health resort as is Asheville, twenty-two miles distant. This is not because it is peculiarly exempt from moisture for the whole year—which I have always doubted was true of Asheville and western North Carolina in general—but from the fact that the other conditions which go to make up a good climate and a safe health resort are fully attained, namely, a dry soil with a *low* water level; small fluctuations in the ground water; good mean temperature for the year; plenty of sunshine; a sufficiency of ozone, and no emanations from the soil which are prejudicial to health.

I do not mean to say, as some have said, nor to be understood as saying, that this climate combines all that is essential for all classes and cases of consumption; but I do mean to say that in those cases of phthisis in which the absolute amount of moisture is not the main consideration, but in which plenty of outdoor exercise in the sunshine and in an air of an exhilarating and stimulating character and free from dust and organic impurities is needed, a most beneficial effect may be expected from residing here or in some place similarly situated.

I must take exception to the assertion, sometimes made, that consumption is not found in western North Carolina. I have frequently met with it here, as must inevitably be the case elsewhere if we take the modern view of the pathology of this disease. I also doubt that it will always be arrested in this section, although I agee that many cases of catarrhal phthisis are improved and rendered less severe here. The class of cases which I have so far seen most benefitted have been of the catarrhal type and in the first stages. I can affirm from a general and extended experience of many years that an abundant supply of sunshine, accompanied by an exhilarating soft and bracing atmosphere, free of almost all kinds of impurities, is attained in this latitude. When, therefore, these adjuvants are desired, either in cases of consumption or in any other affections, I do not think that more could be accomplished save in the far West, or in Arabia, more distant still.

I append a tabular report of the meteorological condition of this place and of some others, and I think, after a careful review of the figures, that we can safely say that none are entitled to the name of dry climate save Denver and Cheyenne. In many respects the Flat Rock summer climate corresponds to the Jacksonville winter climate, enjoying most of her advantages and none of the disadvantages incident to winter.

The altitude, together with the moisture, renders the air soft and balmy, and we have thus the good effects of a Florida climate coupled with the exhilarating and tonic effects of the air of an elevated region. The nights are cool and pleasant, and the moisture, which with the increase of barometric pressure at a lower altitude would render the air close and heavy, is at this altitude changed into a light and soft atmosphere, soothing, invigorating and strengthening to the nervous system, instead of one debilitating and enervating.

	Mean Annual Temp.	Highest Temp.	Lowest Temp.	Mean Relative Humidity.	Average Rain fall in inches.	Mean Max. Temp.	Mean Min. Temp.	Number of clear days.	Elevation above sea level in feet.
Flat Rock	62.5°	87.5°	3°	*77.8	40.14	—	—	—	2,226
Asheville	54.1°	94.0°	6°	70.3	42.55	64.3°	46.0°	259.0	2,250
Charlotte	60.6°	101.0°	5°	66.7	54.10	69.7°	51.9°	251.8	808
Charleston	66.2°	103 0°	13°	73.1	59.91	73.1°	60 2°	274.8	52
Jacksonville	69 5°	104.0°	19°	71.2	55.31	77.9°	62.2°	280.0	43
Atlanta	61.7°	99.4°	13°	67.4	56.23	69.4°	52.9°	260.1	1,129
Denver	49.3°	105.0°	29°	46.5	14.99	61.5°	37.4°	309.3	5,204
Cheyenne	44.1°	100.5°	38°	52.2	11.07	56.2°	30.9°	302.9	6,105

* The mean relative humidity is too high, being calculated from two few months. It would correspond to that of Jacksonville if computed for the year. The rain fall is also possibly a little too low.

A CASE OF NORMAL OVARIOTOMY.

BY LLEWELLYN ELIOT, M.D.,
WASHINGTON, D. C.

The following is the history of a case upon which the late Dr. Johnson Eliot operated, and it is reported on account of the age of the patient:

M. F., white, 58 years old, born in Ireland. Previous history negative. Her menstrual periods have always been regular; the last one occurred ten years ago. She has had seven children. Eight months previous to the operation she noticed that the abdomen was gradually enlarging, and, as she expressed it, she felt as if she was pregnant. In February the enlargement increased rapidly and operative procedure was deemed advisable. On March 14, 1883, the patient was etherized, the abdomen washed with a solution of carbolic acid, and under the carbolic spray an incision four inches in length was made along the linea alba; the sac was exposed and its contents evacuated. An attempt was made to use the Spencer Wells trocar, but, owing to the colloidal character of the fluid, this was impossible; so the contents were turned out with the hands. About a quart of very dark-green fluid gushed out. The sac was situated on the right side, was multilocular, and was estimated to weigh twenty-eight pounds. The sac was drawn out of the abdominal cavity and held with a clamp; the pedicle was tied with carbolized Chinese silk, divided and dropped into the cavity. After arresting bleeding and thoroughly drying the parts, the external wound was closed with five carbolized silk sutures, the whole covered with carbolized lint and held in place by bands of adhesive plaster. Reaction was good. A hypodermic injection of morphia sulph., gr. ¼, was administered and the patient put in bed. At 8 P.M., the temperature was 99⅗°, pulse 92; the pupils were contracted; there was no pain. She was ordered warm milk diet, and five minims of tincture of aconite (Fleming's). At 10 P.M., the temperature was 99⅖°, pulse 84; no pain; morphia sulphate, gr. ¼, given hypodermically.

March 15, 6 A.M. Temperature 99⅘°, pulse 92; no pain; warm milk diet continued. At 10 A.M., she had rumbling in the bowels, but no pain; morphia sulph., gr. ⅜, given hypodermically; and tincture of aconite, ♏ iij. The patient has urinated four times since the operation, without pain or difficulty. 6 P.M. No pain; has nausea. Ordered tincture of aconite, ♏ iij, with morphia sulphate, gr. ¼; carbolic acid (No. j), gr. ½. 12 P.M. Temperature 100⅖°, pulse 92; no pain, no nausea; has slept, and has urinated without difficulty or pain.

March 16, 2.15 A.M. Temperature 101⅕°; pulse 94, strong and full; skin hot and moist. Ordered tincture of aconite, ♏ ij. Feels very well, except an emptiness of the stomach; no nausea. 12 M. Temperature 100°, pulse 94; complains of itching about the wound.

March 17, 2.15 A.M. Temperature 100⅕°, pulse 90; skin moist and soft; complains of no uneasiness. 7.15 A.M. Temperature 99⅕°, pulse 88; passed a good night. 12 M. Temperature 99°, pulse 84.

March 18, 10.25 A.M. Temperature 98⅘°, pulse 80; passed a good night. Dressings changed. There has been no discharge; wound closed; no tenderness; milk and boiled rice diet.

March 19, 10 A.M. Temperature 99⅖°, pulse 84. 9.30 P.M. Temperature 100, pulse 78; morphia sulphate, gr. ⅙, hypodermically.

March 21, 22, 23. No observations taken; morphia sulphate, gr. ⅛, given each night, as before.

March 24. Bowels moved.

March 25. Sutures taken out, the central one being followed by a few drops of blood. This blood was caused by a slight tear in the integument. No pus was present, no pain complained of, and no tenderness on percussion.

March 28. Patient sat up. From this date no observation was recorded, as the progress of the case was unattended by any change calling for attention. She soon resumed her household duties, and has continued well. She has a small ventral hernia at the lowermost part of the cicatrix, but it gives her no uneasiness.

EXCESSIVE MEDICATION.

BY O. L. ABBEY, M.D.,
WATERFORD, PA.

How many of us in the first years of our practice medicate too much? We are not always quite sure of the disease, but sometimes think we are, and give medicine expecting to shorten its course or to abort it. In after years we treat similar cases with one quarter the medication we then used, and think a great deal of our former medication was not indicated. Many practitioners give compounds which are absurd. I can call to mind following the advice of consultations, when there were two or three compounds

suggested, each compound containing four different ingredients, and the patient getting as many as twelve different medicines. Now, if these were all good for the patient, why would it not have been wise to try two at a time? I have been called in consultation where, before I was called, the physician had tried everything in the materia medica indicated for that disease.

When I was asked if I could suggest anything different, I wondered the patient could withstand so much. We laugh at the homœopathist giving, Ac., Bel., or Mercurius, No. 10, No. 15, etc., at intervals of ten or fifteen minutes. But if some of the compounds we prescribe every three hours were separated and given singly one would be administered quite as frequently. There are times when the friends of a patient feel that they are not doing much for a sick person if the medicine comes only at intervals of one and a half hours. In such cases I would extemporize some simple thing to fill in and keep them busy. My best success in treating fevers has been where I medicated very little.

If a drug does not do good in a certain case the patient fares better without it, for it may do absolute harm. This is especially true in acute cases. How many men have used spirits of nitrous ether for some time before they found out that, in kidney troubles, where there is acute or chronic inflammation, it does absolute harm; and that it is useful in kidney trouble only when the kidneys need a stimulating diuretic.

Of course in this day, when everything is run through at railroad speed, a patient's friends want to see something done most of the time. This is especially true in small towns, where physicians dispense their own drugs, where there is no pharmacist's bill to pay, and where the friends may be believers in homœopathy, such friends are always ready with their advice, and free to say that their doctor gives them Ac. and Bel. or Kalium; and if the pain is in the right ovary they give them Apis. and Bel., and if it is in the left ovary they give Lach. every ten or fifteen minutes. These exigencies must be met; but let it be done with simple things, and by attending to the hygiene of the room, and as much as possible by means of local applications, instead of drugs.

Last winter I was confined six weeks with acute bronchitis. I ran the scale on aconite, gelsemium, ipecac, muriate of ammonia and squills; but notwithstanding all these remedies it took six weeks for me to get well, and I received benefit from only two things: veratrum viride and Dover's powder. I think if I had kept my bed and taken nothing but veratrum viride at first, and followed it with the Dover's powders, I would have got along just as well and perhaps better. I have treated severe cases of acute pneumonia with veratrum viride, followed by ipecac, this being the only two medicines I have used. I have no doubt that in many cases of fever, where so much medicine has been given, nature effected the cure, and the patients recovered in spite of the treatment. Many cases of fever will do well with a good diuretic, given until the fever abates, and followed by quinine. Giving a medicine for every symptom arising in the course of a disease is too much like the plan of the homœopaths who give different remedies for pain in the right or left ovary. This may display good theoretic knowledge; but is it good for the patient? I knew a physician, who died twenty years ago, who had an extensive practice in the country. He had a great reputation for treating fevers, and his practice was so extensive that often he could see his fever patients only once in every three days, and of course his medicine was not changed during that time. Usually his patients had only two things to take. He medicated but little, and his success was above the average; among his strongest points was the fact that his good judgment told him what not to give. This is one great secret of success in the practice of medicine.

I think that one reason why so many intelligent people are homœopathists depends upon the fact that they think that, if their medicine does not do any good, it does no harm. When I think of the many medicines used in the present day, it seems to me important to ask: Is the percentage of cures of acute diseases any larger now than it was twenty-five years ago, when but a small part of the remedies we have now were known or administered?

—An official notice has been published by the Berlin *Deutsches Tageblatt* of Nov. 17, which gives some information regarding "Warner's Safe Cure." The announcement describes this preparation as a brown liquid in flat bottles, containing about one pint, which has been for some time recommended for kidney complaint, and sold at the price of $1.00 a bottle. The official chemical examination of the same, together with the declaration of a Berlin apothecary who introduces it, makes known that its essential ingredient is American wintergreen, and that the bottles are, at the highest valuation, worth only 50 cents each.

Society Reports.

OBSTETRICAL SOCIETY OF PHILADELPHIA.

Thursday, February 2, 1888.

Thos. M. Drysdale, M.D., in the chair.

Dr. B. F. Baer presented the specimen, and read the report of a

Case of Non-Papillary Intra-Ligamentous Cyst,

in which he had enucleated the entire tumor in the right broad ligament, but only the lining membrane of the cyst in the left broad ligament.

Sessile tumors, whether cystic or solid, are always more or less dreaded by the operator, because of the greater difficulty and danger attending their removal, and also because, in the case of sessile cysts, the result as to the permanent relief of the patient is less certain than where the tumor has a pedicle. Clinically and pathologically, therefore, these cases are of great interest and importance. Pain and hemorrhage are the important subjective symptoms. The former is usually present, sometimes in great severity; the latter is at times alarming in the quantity of blood lost and in the frequency of its recurrence. This is not surprising when we consider the close relation which these tumors sustain to the uterus and to the other pelvic organs and tissues. The wedging and pressure which result from the growth of the tumor in the limited space produce great congestion of the blood-vessels from stasis. The uterus becomes enlarged and softened in consequence, and metrorrhagia follows; but the hemorrhage is conservative to a certain degree in relieving the distended vessels, probably averting rupture of a vein in the broad ligament or in the tumor. The pain which results from the tension and stretching of the nerves involved is also relieved or modified by the depletion following a free hemorrhage from the womb. But the flow once started, does not always remain within the conservative line; it sometimes becomes uncontrollable, and results in acute and serious anemia.

According to Doran, sessile cysts which arise from the hilum of the ovary or from the Wolffian relics in the broad ligament are usually papillomatous; but that non-papillomatous sessile cysts infiltrating the broad ligament are not infrequently met with is shown by the following statement from that author: "In twenty-four cases where I assisted at the operation, sessile cysts infiltrating the broad ligament were removed, more or less completely, but their origin could not be ascertained; none of them contained glandular growths, most were multilocular, but papillomatous growths did not exist." (Tumors of the Ovary, etc., p. 68). Further, the ordinary pedunculated multilocular cyst of the ovary sometimes contains papillomatous growths, the result possibly of stray Wolffian relics. I have presented at least one such specimen to this society, and I have seen others. On the other hand, the multilocular ovarian cyst without papillomatous material has been found, in rare instances, to have invaded the hilum and broad ligament in its growth. Doran records two such cases. He says: "I have seen two cases where a sessile cystic tumor of the ovary was removed, and this proved to be an undoubted case of glandular cystic disease, invading the hilum and the broad ligament." The case which I here report is probably another instance of this pathological anomaly.

Mrs. X. was sent to me by Dr. O. H. Adams, and entered my private hospital in April, 1887. She is 32 years of age, married, and has had three children, the last two (twins) eight years ago. Following her last labor she had puerperal mania, which necessitated her confinement in an insane asylum during four months. Two years ago she began to have attacks of sharp pain in the right ovarian region, radiating to the groin and down the anterior portion of the thigh. The pain was intermittent in character and cramp-like, lasting hours at a time, and was usually followed by a purulent, fetid discharge from the vagina, which would afford her great relief. At other times the attack would end with a profuse metrorrhagia, which would leave her pale and weak, but free from pain. About two years before coming under my care, she first noticed a "lump" in the right groin, which has gradually increased in size. Sometime after, she noticed a similar growth above the left groin. She was considerably emaciated and looked very ill. Examination revealed a tumor as large as a child's head in the right iliac region, and a smaller one in the left ovarian region. The tumors seemed to be fixed in the pelvis, and to have a broad base of attachment; they were immovable below but mobile above, and semi-fluctuating. Vaginal examination showed them to be so deeply attached in the pelvis and so intimately related to the uterus, that I was

unable to complete my diagnosis without anæsthesia. The patient was therefore placed in bed and ether administered, when it was found that the uterus was elevated by the tumor on the right side with which it was connected. There was evident fluctuation, though the tumor was thick-walled and very firm, almost hard. The lower surface occupied the position of the broad ligament at the side of the uterus. The same condition existed at the left side, but to a less degree. I diagnosticated sessile cystic disease of both ovaries or broad ligaments, and advised immediate operation, to which the patient gladly consented.

On April 13, 1887, I proceeded to operate, being kindly assisted by my friend Dr. Daniel Longaker. When the tumors were exposed, they were found to be so closely connected with the womb, that they seemed to be one with that organ, which rested as a wedge between them. The Fallopian tubes extended outward over the upper surface of the tumors, while the broad ligaments and the greatly distended veins of the pampiniform plexus were expanded so as to apparently envelop them, the whole presenting a dark, purple appearance, which was not at all reassuring. After separating some slight adhesions on the posterior aspect of the larger tumor, and rolling it forward, the nacreous surface common to the multi-locular ovarian cyst was exposed to view. Selecting a spot on this free surface because it was less vascular, I now plunged a trocar into it, when about two pints of a tarry-looking fluid drained away. A more thorough investigation, which the diminished size of the tumor now afforded, showed it to be adherent to the cæcum also. Previous to beginning the enucleation, I passed a long blunt needle charged with a double ligature through the expanded broad ligament at its least vascular portion, between the uterus and the tumor, and as far below the Fallopian tube as could be done with safety. One side of the ligature was then drawn up and tied close to the uterus, including within its grasp the tube and vessels. Thus insured against hemorrhage from that source, I now cut through as far as the ligation extended, and continued the enucleation down to the base of the tumor, and then outwards, finally separating it from the head of the colon. There was some bleeding from the numerous veins which were broken, but this was readily controlled by catch-forceps and ligatures. Attention was now given to the tumor on the left side. This was found to be deeply imbedded in the pelvis and firmly fixed to the uterus, Fallopian tube, descending colon and rectum. The upper surface was covered with a network of distended veins, some of them as large as a quill. Enucleation of this tumor seemed too hazardous, and hysterectomy was out of the question; for to do the latter the tumor must first be dissected from the colon and the pelvic floor, which was not practicable. I determined, therefore, to evacuate the contents of the cyst by aspiration and then to shell out the lining membrane, or, failing in this, to insert a drainage-tube into it. But, while endeavoring to find a position for puncture, my finger passed into the tumor low down on the posterior border of the broad ligament. Instantly the parts were flooded with a tar-like, semi-fluid substance similar to that which had been evacuated from the cyst on the right side. This was removed as quickly as possible by sponging. I then passed my finger through the opening which I had thus accidentally made, and after a careful and gentle dissection succeeded in removing the entire secreting surface of the cyst. Blood was now flowing from the small valvular opening in the broad ligament, but as it was apparently venous I hoped to check it by compressing the now flaccid folds of the broad ligament. For this purpose several large sponges were inserted and external pressure made upon them while the abdominal sutures were being placed. The sponges were then removed. There was still a slight flow of blood, but as it was doubtless only a venous oozing I concluded to close the wound and trust to pressure and the drainage-tube. The patient was placed in bed and the tube carefully watched. During the next two or three hours several teaspoonfuls of quite bloody serum passed through it; after forty-eight hours the tube was removed.

This patient made a slow, but good recovery, and went home six weeks after the operation. She has been entirely relieved of her former sufferings, and the loss of weight and strength have been regained.

Dr. Wm. Goodell reported

A Case of Splenectomy.

Mrs. R., aged 40, had chills and fever in early life, but after her marriage, 18 years ago, she removed to a healthy country town and had no return of the disease. She has had two children, the youngest 7 years ago. At this labor she had a serious flooding and was confined to her bed for six months from excessive prostration. Since that time, she has never been well, being weak and miserable. Her monthly periods were always free

and generally painful. Last March she had a very severe attack of what her physician called malarial fever, and her life was threatened by repeated attacks of hæmatemesis and hæmoptysis. A sore tumor was now discovered, which was pronounced to be a uterine fibroid, and she was sent to Dr. Goodell. He found the womb pushed low down and retroverted by a solid tumor, which started from the region of the right ovary and ran diagonally towards the splenic region. It entered the pelvis so low down as to cause bulging of the anterior wall of the vagina. The womb seemed to be independent of the tumor, for the former could be moved about freely with the sound. Yet when the tumor was pushed upwards, it conveyed motion to the womb, drawing it also upwards. The tumor was always painful, and the complexion of the woman was markedly cachectic. The diagnosis made was sarcoma, either of the right ovary or of the omentum.

At the operation a very long incision was needed, reaching not quite up to the ensiform cartilage. The tumor was of a dark purple color and was attached in every direction by very long tortuous and wholly denuded vessels, which looked like the largest earth worms, and were of corresponding length. Most of the vessels came from the omentum, which had disappeared apparently by being incorporated with the tumor and by having its connective tissue and fat removed by absorption, leaving the blood-vessels bare. These vessels were either single or else grouped in large bundles, and had all to be ligated. By them the tumor had evidently been nourished, for what looked like a pedicle, was slender, long and twisted. It was lost in such a mass of livid veins that Dr. Goodell did not dare follow it up to its source. His diagnosis had been sarcoma of the omentum; but he was so uncertain of the character of the growth that he sent the specimen to Dr. Formad, who pronounced it a leukæmic spleen. It weighed not quite six pounds. The woman did did well for four days, then symptoms of embolism set in, the sputa became streaked with blood, and she died on the sixth day. So far as he can learn from the literature on the subject, his case made the eighteenth in which a leukæmic spleen had been extirpated, and all had died save one.

Dr. Harris said that the case of recovery after operation for removal of a leukæmic spleen, spoken of by Dr. Goodell, had occurred under Dr. Franzolini, of Modena, in North-eastern Italy. The proportion of leucocytes was small, which probably accounted for the recovery of the patient. The diagnosis had been made before the operation.

Dr. Parish had a few years ago seen a case with late Dr. Wallacé, in which a diagnosis of the fibroid of the uterus had been made. A tumor the size of the two fists was found near the side of the uterus. The patient developed peritonitis and was tapped by the assistant physician; some dark fluid was withdrawn. Death took place a few months after, the peritonitis having been cured. At the autopsy, the spleen was found adherent to the uterus and to the pelvic brim.

Dr. Goodell called attention to the hæmoptysis and hæmatemesis in his case, which were the usual symptoms of a leukæmic spleen; but he had not been informed of them until after the operation had been performed, and, therefore, he did not have that clue towards forming a diagnosis.

Dr. Hamill exhibited

A Uterus Removed from a Woman in the last Month of Pregnancy,

and said: The opportunity to examine the uterus at an advanced period of pregnancy is not often afforded; and as this particular specimen presents several well-marked and interesting features, I felt that it would be of interest to place it before the society. The uterus was removed about twenty-four hours after death. I was present when the patient died and wished to remove the uterus immediately, but could not obtain the consent of the family. I shall very briefly call attention to the several conditions noticed: The outer surface of the uterus is studded in many places with syphilitic nodes. The woman had contracted syphilis early in her married life, and manifested other marked symptoms of the disease. There is also a small cyst of the broad ligament. The specimen presents quite markedly the contraction ring, or ring of Bandl. I give both designations advisedly, inasmuch as it is not definitely determined whether this ring represents the internal os, as Bandl asserts, or marks the boundary between the upper and lower uterine segment, as Schroeder believed. According to the investigations of MacDonald, Müller, Sänger and Lusk, this condition does not always exist. In three autopsies made by Lusk, he failed to find any trace of Bandl's ring. Schroeder, in a frozen specimen, found this ring very distinctly, but claimed that it was the dividing line between the upper and the lower uterine segment. Bandl holds the contraction ring of Schroeder to be the true internal os, and consequently one would expect to

find below this ring cervical mucous membrane, whereas the portion between Bandl and Müller's ring is covered by decidua. Bandl explains this by his three hypotheses: (1) the decidous membrane is crowded down into the cervix by the weight of the presenting part; (2) in primiparæ the advancing head strips off the mucous membrane, which is replaced by decidua; (3) the cervical mucous membrane is transformed into decidual membrane during pregnancy.

Another interesting feature, which the specimen demonstrates beautifully, is that condition pointed by Leopold and Lusk as seen in their Cæsarean sections, viz., the delicate filamentous bands running from the chorion to the decidua, which are the atrophied villi of the chorion. The attachment of the placenta is to the posterior wall of the uterus.

NEW YORK ACADEMY OF MEDICINE.

Stated Meeting, February 16, 1888.

The President, A. Jacobi, in the chair.

Dr. Idele A. Seibert read a paper upon

Cholera Infantum and the Weather,

and gave as his excuse for doing so the fact that, while much had been said upon it, definite knowledge had not been arrived at.

Dr. Seibert had collected all the cases of acute gastro-intestinal catarrh in children under five years of age occurring at the German dispensary during the period of ten years, from 1878 to 1888, and had compared their frequency and severity during the several months and years with the meteorological phenomena during the corresponding dates. The total number of cases was 8036. Of these the largest number occurred during the warm weather months, June, July, August, September, October, and the fewest during the remainder of the year, the cold weather months, so that we might properly continue to call it a summer complaint. But its relation to heat, to moisture and to winds was not what many had been led to believe. His statements in this respect were founded on a study of several charts in which the figures given were thoroughly analyzed and compared. Besides a study of these eight thousand cases, he had also made a study of the number of deaths from the same disease during the same period of time, as shown by the statistics at the Board of Health. The following statements grew out of his investigations:

1. Hot weather, either dry or moist, is not necessary for an epidemic appearance of summer complaint.

2. Warm weather, either dry or moist, showing minimum daily temperatures of not less than 60° F., brings on the epidemic appearance of cholera infantum invariably in every year, irrespective of the height of the maximum degree of daily temperature, as in the latter part of June of nearly every year.

3. Summer complaint loses its epidemic character as soon as the minimum daily temperature falls below 60°, as in the latter half of October of nearly every year.

4. Therefore this disease cannot be brought about by the direct working of high temperature on the infantile body, but must have other causes.

As to what these other causes might be, Dr. Seibert was of opinion that it was chiefly spoiled milk. It had been shown by Dr. Edson and others that milk readily decomposed when of a temperature of 60° or above. That which was brought to the city was usually milked in the afternoon or evening, and transported to the city during the hottest hours of the day, and was jostled over the streets before reaching the consumer, being thus subjected to all the conditions favoring decomposition. His statistics also showed, contrary to general belief, that the mortality from summer complaint was less during August than during July. This difference might be accounted for in different ways, the chief one being probably that parents had their attention more fully aroused by that time to the necessity for proper precautions.

The paper was discussed by Drs. L. E. Holt, J. Lewis Smith, A. Caillé, A. M. Jacobus, and the President, most of whom expressed the opinion that cases classed as summer complaint were not all of one disease.

The President believed that cholera infantum proper was in a measure due to the action of heat, as most cases occurred during a hot spell; while ordinary cases of acute gastro-intestinal catarrh, which were the more frequent, existed during warm months, when the temperature could not be called hot.

Dr. J. Lewis Smith thought the cases occurring during the cold months had not the same origin as those developing during the warm months. Those who had given most thought to the cause of summer complaint, he said, were of the opinion that it is due to a micro-organism.

Reports of Clinics.

HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA.

MEDICAL CLINIC—PROF. OSLER.

Multiple Aneurism of the Aorta.

The post-mortem specimens from this case were brought before the class. The first sac took its origin from the upper part of the ascending portion of the aortic arch. The body of the tumor bulged forwards, pressing against and eroding the manubrium, the ends of the clavicle, the costal cartilages, and first and second ribs of the right side, and formed an external mass as large as a cocoa-nut. The skin had been eroded at two points, situated over the most prominent portion of the sac, and through these openings a slow but constant hemorrhage occurred. A second aneurism, filled with firm laminated clots, was found at the beginning of the descending portion of the arch, and a third was situated below the diaphragm, just above the origin of the cœliac axis. This also was filled with firmly organized clots.

Previous to his death, this man had complained only of some pain in the chest and moderate dyspnœa on lying down. Otherwise he was in excellent health. The cause of death was exhaustion consequent upon the uncontrollable hemorrhage carried on through the two erosions in the skin. Fatal hemorrhage from external openings such as these is of exceedingly rare occurrence. The heart was found to be very slightly enlarged; aneurism seldom produces any cardiac hypertrophy.

Pneumonia.

The patient was a man, 34 years of age. He had had a bad cough for a week previous to his admission. On the day before he presented himself here the cough grew much worse, dyspnœa became a prominent symptom, and increased pain in the right chest occasioned much distress. There were also heightened temperature, chilliness and vomiting. On admission, the temperature was 101°, respirations 36, pulse 82. The cough was frequent, and accompanied by a rusty sputum. Percussion on the right side gave a high pitched note in the lower axillary and infra-scapular spaces, but auscultation only a few indistinct râles, without definite blowing breathing. The temperature rose rapidly during the ensuing night, and by morning had reached 104°. Here it remained throughout the day, and then fell to the normal within the next thirty-six hours. The treatment consisted in nitric ether and citrate of potash, and dry cups over the affected area, followed by poultices.

Remarks.—The lecturer regarded this case as a striking instance of a class of pneumonias in which one might find all the rational symptoms of this disease with an utter absence, or scarcely appreciable presence of any of the physical signs. Three or four days may pass, during which cough, thoracic pain, rusty sputa, quickened respiration, and high temperature may possibly be well marked, before the local signs of exudation and solidification reveal themselves. It is to be remembered that the lung is an organ of considerable capacity; that it fills quite a large space; and, hence, if the inflammation happens to be deep-seated or central, it will take very careful auscultation to discover the customary râles. It is only when the pneumonia is superficial that the râles and blowing respiration are of easy recognition. As to the treatment of a mild, uncomplicated case such as this, it is, of course, very simple. Scarcely anything more is necessary than confinement to bed, and a mild aperient and diaphoretic course of remedies.

Pleurisy; Empyema; Phthisis.

This young woman, aged 28, was admitted to the hospital last March with all the signs of pneumonia of the right base. She was placed under treatment for that disease, and in a reasonable time the cough lessened, the sputa diminished, the respiration became less frequent, and the pneumonia seemed to have run its course; but, in spite of all this, the temperature remained high and dulness was still found at the base of the lung. In addition, the patient had several chills, and there occurred profuse sweating. It was then discovered that an empyema existed, and, a short time subsequently, the lung displayed unmistakable evidences of tuberculosis.

Now the question arose: "Was this principally a case of pleurisy, tubercular in its origin, or was it a case of what has been called acute pneumonic phthisis, with the pleuritic lesion secondary to it?" Many authorities now assert that the large majority of pleurisies are really of tuberculous origin, and that they are preliminary to, or are accompanied by, tubercular deposits in the lungs. Dr. Osler thought this was going too far. He grants that many cases of pleurisy have this for their exciting cause, no doubt; but he is not

yet ready to accept the doctrine that the majority of them are due to it.

Gastro-Intestinal Dyspepsia.

John S., aged 56, ship's steward, has suffered more or less constantly for several months from imperfect digestion. During the last three months an obstinate diarrhœa has added greatly to his discomfort, and it is for this disorder that he now applies for treatment. He averages about four stools in the twenty-four hours. There is no tenesmus, no blood, and no pain of any account. There is an entire absence of that tenderness over the large bowel which would indicate the existence of ulceration. Chronic dysentery is thus excluded. The patient has noticed that the diarrhœa is markedly influenced for the better by a restricted diet. A full meal, on the other hand, is followed by an aggravation of the diarrhœa and by a distressing degree of flatulence, the wind passing, as the patient says, "both ways." From these facts the case is diagnosed as one of gastro-intestinal dyspepsia, the mass of semi-digested food being responsible for the appearance and continuance of the diarrhœa.

Treatment.—The lecturer thought that certain of the artificial digestive ferments might be employed here with advantage. Preparations containing pepsin, pancreatin, etc., were clearly indicated and would, doubtless, prove of benefit. In addition to these, however, Dr. Osler spoke warmly of the value of naphthalin in doses of v to viij grains, taken in capsules immediately after meals. Should the diarrhœa persist, bismuth was to be used in preference to any other remedy, but it must be given in larger doses than those usually prescribed. Grains xv–xxx should be given three times daily in order to secure a favorable result.

—A new and ingenious test for detecting the addition of water to milk is reported, based upon the fact that all well and river water contains nitrates of either calcium, sodium, potassium, or ammonium in varying proportions. The presence of either of these, according to the source of the water, may easily be determined in the residue left upon evaporation of the water. These nitrates, in the proportion present in the drinking water, produce a blue color with diphenylamine sulphate. In testing, twenty drops of the diphenylamine sulphate is placed in a saucer and a little of the suspected milk poured into it. In the presence of only five per cent. of well water of ordinary quality in the milk, it will gradually assume a blue tinge.—*Quarterly Therapeutic Review*, January, 1888.

Periscope.

Case of Poisoning with Potassium Bichromate.

Dr. W. Norton Whitney, in a communication to the *Sei-I-Kwai Medical Journal*, of Tokyo, Japan, December, 1887, reports that a case of poisoning by potassium bichromate recently came under his notice, which he thinks worthy of reporting on account of the large amount of the substance ingested, and the fortunate recovery made through prompt use of antidotal measures. The patient was a young married woman, about two months pregnant, who through mistake took a swallow of a saturated solution of potassium bichromate, which had been used for charging a carbon battery, and also contained sulphate of mercury and sulphuric acid. The fluid had been carelessly placed in a Crosse and Blackwell fruit bottle, marked "Raspberries," and was supposed to be raspberry syrup. The amount of fluid ingested was estimated to contain about twenty-four grains of the bichromate and three grains of the sulphate of mercury. Immediately upon its ingestion it occurred to her, from the astringent taste of the fluid, that she had taken poison; and, recalling the fact that the white of an egg is a safe antidote for corrosive poisons, she immediately, and within five minutes after she had taken the fluid, swallowed the white of one egg. Nausea and vomiting of a bright yellowish substance immediately followed. The nausea and vomiting continued for some time. Dr. D. B. Simmons was called, and ordered some more white of egg, and some warm water and bicarbonate of soda, which were given about half an hour after the poison had been taken. At this time the nature of the fluid taken had not been discovered. Nausea and vomiting continued for about seven hours after, vomiting taking place about twenty times in that interval. Four hours later, castor oil was given, which acted in a few hours. Eight hours after ingestion of the poison, a slight hemorrhage from the genitals began, and continued for a short time, not amounting, however, to more than a drachm altogether. The patient had been sent to bed an hour after the taking of the poison, and she remained there for forty-eight hours. The fifth day after the accident she was carried in a hammock twenty-two miles, and on the sixth day rode by railway sixty miles to Tokyo. No ill effects have since been noticed, and the gestation had proceeded up to the time of the report three and one-

half months more. It is a matter of doubt in the author's mind as to whether the hemorrhage was due to the oxytocic nature of the poison, or to the violent and continued emesis; the fact, however, of there being so little hemorrhage and its early arrest, although a miscarriage at six weeks had taken place a year previous, points to the probability that it was entirely due to the vomiting.

Contractions of the Uterus during the Whole of Pregnancy.

Dr. J. Braxton Hicks, who is well known for his investigations upon the contractions of the uterus during pregnancy, has recently communicated two papers on the subject to the *Lancet*, January 14 and 21, 1888. The following is a brief *résumé* of these papers: 1. During the whole of pregnancy the uterus contracts at intervals, which vary much, but commonly last from five to twenty minutes, and it remains in contraction for a shorter time, say from three to five minutes. 2. If the examining hand is placed at the time of contraction on the uterus the latter will be firm, pear-shaped, and the fœtal parts not readily, if at all, detectable; if the hand is placed on it during the state of rest, or is allowed to remain on till the firm state is passing off, then the outline of the uterus is indistinctly felt; sometimes it cannot be felt at all, while the fœtus can be more or less clearly made out and can often be pressed with the fingers outside into various positions, even as early as the fifth month. 3. By noting these facts, we are enabled with ease, in general, to decide as to the existence of normal pregnancy, to diagnosticate between this and various tumors, both uterine and abdominal, between pregnancy and distended bladder, and other conditions easily called to mind by the practitioner. 4. That these intermittent contractions have the physiological use of emptying the loaded uterine veins, changing highly carbonized blood for that more aerated. 5. That from observations which he has made he is inclined to think that there is some pretty constant relationship between the accumulation of this highly carbonized blood and the fœtal movements, and also between the fœtal movements and the uterine contractions.

Restored to Sight after sixty years of Blindness.

In the *Lancet*, January 7, 1888, Dr. David McKeown reports the case of a fiddler, 63 years old, who had been blind, when first seen by Dr. McKeown in August, 1883, for sixty years. When one and a half years old, he lost the sight of both eyes from an attack of small-pox. The right eye lacked perception of light, but the perception of the left was good. There was a dense central opacity extending into the upper half of the left cornea, and the iris was adherent all around to the margin of the opacity. An iridectomy was performed, opposite the transparent cornea above, which was the only place available for such a purpose. A year after the operation, his condition was about as follows: the cornea opposite the artificial pupil was a little milky; the use of the eye was attended with some difficulty, on account of the position of the artificial pupil, which caused strain upon the inferior rectus; the presence or absence of the lens could not be determined; the result of a trial with glasses was practically *nil;* the vision which he had gained by the operation enabled him, when in the streets, to dispense with the stick, which, before the operation, was a necessity; he could count objects of a line and a half in diameter when about a line distant from each other; he recognized comparatively small differences in size. His color perception was good, and his color education progressed very rapidly.

The author regards this case as unique, considering the early age at which vision was lost, the prolonged period of blindness, and the gratifying result of the operation.

Differential Diagnosis of the Different Syphilitic Ulcers.

G. Wertheim states in the *Weiner med. Blätter*, 1887, No. 11, that he believes that he can, in every case, say with certainty whether he has to deal with a hard chancre or a soft, or so-called mixed chancre. His method of procedure consists in first treating the pus of the chancre with a solution of vesuvin (one thousandth of one per cent.); then with a solution of caustic soda, hydrochloric acid, chloride of sodium and distilled water. According as the resulting crystals form themselves into a granular structure, or into sheaves, or show a combination of granules and sheaves, the sore is one or the other of the three kinds of chancre. The author promises a successful result from the investigation only when his highly minute directions are followed in the most accurate manner; and the details of the method cannot be reproduced in an abstract.—*Centralblatt f. d. med. Wissensch.*, December 10, 1887.

Perichondritis of the Larynx.

At a meeting of one of the medical societies of Vienna, on December 5, 1887 (*Deutsche med. Wochenschrift*, January 26, 1887), Dr. Schnitzler exhibited a case of marked perichondritis of the larynx which had been cured. The patient was taken sick at the end of December, 1885, with cough and hoarseness, and was subsequently unsuccessfully treated by Prof. Schrötter for two months with local applications of iodine and glycerine, and nitrate of silver. He then came in July to the polyclinic complaining of severe horseness, cough, and difficulty in swallowing. There existed at this time a swelling of the whole mucous membrane of the larynx. The epiglottis was thickened, and on both sides of it were ulcers; the arytenoids were decidedly thickened, the vocal cords reddened and swollen, but the inter-arytenoid mucous membrane unchanged. The presence of ulcers upon the epiglottis, while the larynx remained intact, was in favor of syphilis, although tuberculosis was suggested. There was dulness at the apices of the lungs, but an examination for tubercle bacilli gave a negative result. The patient explained that he never had had syphilis, but that ten years before he had had gonorrhœa which was complicated with buboes, and that there never had been any secondary symptoms. Insufflations of iodoform, sprayings with solutions of corrosive sublimate, and inunctions had no effect; on the contrary, the swelling decidedly increased, so that the patient nearly suffocated. Recovery followed the use of iodide of potash from three to five times a day for six weeks.

Case of Cystic Goitre Treated by Enucleation.

In the *Bristol Medico-Chirurgical Journal*, December, 1887, Dr. C. T. Vachell reports a case of cystic goitre, which occurred in a woman 22 years old, who was admitted to the Cardiff Infirmary, October 19, 1886. She had first noticed the tumor about nine years ago, and since then it had slowly and painlessly increased in size. Latterly, it had somewhat interfered with breathing, there being occasionally a choking feeling. At the time of her admission the tumor was about as large as an orange, and occupied the front of the neck, inclining to the left side. It was painless, firm, and fairly movable, fluctuated distinctly, and rose and fell with the act of swallowing. One large artery was felt entering at its right upper margin. An exploring needle was introduced, and it was found to be a single cyst and to contain fluid of a reddish color. On October 27, chloroform was administered for the purpose of "shelling out" the cyst, but the patient became so pallid that it was not considered advisable to proceed; four ounces of a reddish fluid were, however, removed with the aspirator. By October 30, the cyst had refilled; and on November 3, the patient was etherized, an incision about two and one-half inches in length was made through the skin, over the most prominent part, and the cyst enucleated. Free hemorrhage occurred from two vessels, which were readily secured, and this done there was no further trouble in the operation. A drainage-tube was inserted and the wound dressed with carbolic gauze. The tumor weighed eleven and one-half ounces, and contained five and one-half ounces of fluid. It measured nine inches in circumference and was unilocular; the walls were from one-eighth to three-sixteenths of an inch thick. Some depression followed the operation, but the patient was discharged, cured on November 23, 1886.

Fatal Hemorrhage from the Tonsil.

Dr. J. N. Hall, of Sterling, Colorado, reports the following case in the *Boston Med. and Surg. Journal*, Dec. 22, 1887: Theodore W., about twenty-six years of age, a cowboy, was attacked with quinsy, about October 16, and bled severely from the mouth. He does not know the origin of the blood, which, he says, amounted to over a quart. He was about twenty miles from a physician at the time, and did not consult the writer until he had bled slightly at several other times. He wishes now (October 30) to know "what to take to get strong again."

At that time there had been no bleeding for several days, and the left tonsil, although somewhat swollen, was not very troublesome. He was given tincture of the chloride of iron, with fluid extract of ergot. After two days, feeling better, he went away from town to the ranch, forty-one miles distant. The next day but one, and during the absence of the writer, he returned, reporting three severe hemorrhages. He was very pale and weak. Dr. C. S. Stone found the origin of the blood to be in the right tonsil, in a cavity left by the evacuation of matter during the attack of quinsy. He applied styptics and no bleeding took place for ten hours. The patient was instructed to press upon the tonsil, in event of bleeding, with the finger. At 10 P.M., and at midnight, bleeding occurred, but was checked by the above plan before the

arrival of medical aid. With the assistance of Dr. Stone, subsulphate of iron was applied to the interior of the cavity. The patient in each hemorrhage lost, by Dr. Hall's estimate, about twenty ounces of blood. He was now pulseless at the wrist, extremities cold, and the heart's action very feeble: 150 per minute. The left tonsil was now greatly swollen, and a little matter was evacuated with a broad exploring needle. Two days later a decomposing clot, nearly as large as a hen's egg, was coughed from the throat, and the tonsil returned to nearly its natural size. For eleven days the patient improved, and was considered out of danger, having been on the street daily for a week. Dr. Hall then continues: "I was called suddenly at 2 P.M., October (November?) 16, to go a distance of one hundred and sixty-five feet to see a very sick man. The time occupied in going was extremely short, but it proved to be this patient lying on the floor moribund. No blood had been lost on the street, but, during the time the writer walked the distance named, the patient had lost blood so rapidly by the mouth and nostrils as to be so far gone that no measures of relief were taken, because they were considered utterly useless. As the writer entered, a stream of blood, as large as could flow, came from the mouth and nostrils, but it stopped shortly. The pulse was perceptible for a few seconds only after arrival.

"No post mortem was obtained. It would seem impossible for death to occur so suddenly from a hemorrhage from any vessel less than the internal carotid. It was learned after death that the patient had stated a short time before that he felt 'something swelling his throat.'

"Probably the ulceration weakened the wall of the carotid artery, and the bleeding came from an aneurismal dilatation of the vessel at that point. Such rare cases have been previously reported."

Corrosive Sublimate in the Treatment of Diphtheria.

J. Stumpf reports to the *Münchener med. Wochenschr.*, No. 12, 1887, that after having passed through an epidemic of diphtheria from May, 1883, to March, 1884, with a mortality of 76 per cent. of the cases, he treated in December, 1884, a boy two and a half years old, who was suffering with diphtheria. He prescribed for this boy inhalations of corrosive sublimate every three hours. These were given by means of a Richardson atomizer, the strength of the solution being one to one thousand. After a few days the boy was restored. Since that time he has treated thirty-one cases of diphtheria exclusively with inhalations of corrosive sublimate, and under this treatment he has lost only one eight-year-old boy in whom, however, the inhalations could be employed only twice. Another nine-year-old boy died four weeks after the beginning of the disease from a sequela. The other twenty-nine cases recovered quickly and completely. Under the employment of these inhalations, in from twenty-four to forty-eight hours the temperature fell from 104° or 105¾° to normal, without the employment of any other antipyretic. Simultaneously with this fall in temperature, there could be demonstrated a marked cessation in the formation of the diphtheritic membrane, which became defined against the healthy mucous membrane of the throat by a clear line of demarcation; the difficulty in swallowing also diminished; the patients desired food and drink, while the membrane, after remaining adherent for from three to five days longer, was then gradually cast off. No symptoms of intoxication whatsoever were observed under this plan of treatment. The only symptom of the action of the mercury was salivation, which was present in every case, but ceased within three or four days after the withdrawal of the remedy.

With reference to the quantity of corrosive sublimate which is thus employed, the author makes the following calculation: One drachm of the solution is necessary for each inhalation; therefore, six ounces suffice for fifty atomizations. Fifty atomizations of a solution, one part in two thousand, will be the maximum allowable dose. But fifty inhalations are scarcely necessary, and besides, more than half of the fluid is rejected by the child. The author employs simply a watery solution of a strength of one part in one thousand for children over six years of age; and for children between two and six years of age, one part in two thousand; while for children under two years of age, one part in three to four thousand.—*Centralblatt f.d. med. Wissensch.*, Dec. 10, 1887.

—A whole family at Versailles, consisting of the parents and two children, was poisoned with conium, which had been used instead of parsley in a dish of vegetables. The patients, being dangerously sick, were taken to the hospital for treatment and recovered. A variety of conium, much resembling parsley, is said to grow in all the backyards and gardens in Versailles.—*Western Druggist*, Jan., 1888.

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ENLARGED SUPRACLAVICULAR GLANDS IN CANCER OF THE STOMACH OR UTERUS.

In October, 1886, M. TROISIER called the attention of the Société des Hôpitaux of Paris to the occurrence of enlargement of lymphatic glands in the supraclavicular region, and especially above the left clavicle, in a certain number of persons with cancer of the stomach. A similar observation was reported by Millard within a week after this; and in the month of November Raymond published an account of a case of cancer of the neck of the uterus in which there was an enlarged lymphatic gland in the left supraclavicular region.

Enlargement of the glands in this situation, in persons with cancer of the stomach or uterus, is not of so frequent occurrence as to have attracted very much attention to the subject; but it is easy to see that, when it does occur, it might be a very important diagnostic sign. For there are not a few cases of disease of the stomach, when the existence of cancer is suspected, in which it would be of great value to have some tangible evidence to confirm the probable diagnosis. The same thing may be said, with less force, it is true, of cases of cancer of the uterus; because it sometimes happens that cancer is suspected under circumstances which make a thorough examination by the vagina impracticable or undesirable.

In the *Gazette Hebdomadaire de Méd. et de Chir.*, Jan. 20, 1888, PETIT reports the case of a woman, seen in 1887, with epithelioma of the cervix uteri, and with a gland enlarged to the size of a pigeon's egg above the left clavicle, which had the characteristics of hard cancer. In the same journal there is a report of a commission composed of MM. Bucquoy, Raymond and Troisier, upon this interesting subject. From the report it appears that Troisier has observed enlargement of the lymphatic glands above the clavicle, attaining the size of a hen's egg, in another case of cancer of the uterus, and he reports a similar case observed by Hutinel as long ago as 1881. Troisier has seen the same thing in a case of cancer of the left ovary.

The observations so far recorded indicate that enlargement of the supraclavicular glands, in cases of cancer within the abdomen or pelvis, is usually associated with similar enlargement of the glands in other superficial situations. But it sometimes occurs by itself. It also usually appears long enough after the implication of the internal organ to make it of less value as an aid to diagnosticating the nature of the internal disease than as an evidence of generalization of the disease, and as an indication that a surgical operation cannot be expected to eradicate it. Nevertheless, as we have stated, it does occur independently, and it also sometimes occurs early; so that in a certain number of cases it may be of great service in establishing a diagnosis which would otherwise be uncertain.

The explanation of this phenomenon, which is offered by Troisier, is that cancer elements are carried by the thoracic duct to the orifices of the ducts of the cervical lymphatics, and thence, by a *reflux*, to these glands. This explanation appears to us entirely unsatisfactory, and we cannot find any which

is less so. But, even if the explanation of the occurrence is not what we might wish, the occurrence itself is of sufficient importance to warrant calling the attention of our readers to it. For the region concerned is one so accessible to investigation that surgeons may well include it in any examination they may have an opportunity to make; and it may be that, if attention be directed systematically to the matter, it may be found that enlargement of the supraclavicular glands occurs oftener than has been heretofore supposed in cases of cancer of the abdominal or pelvic viscera, and that this enlargement may be a very valuable aid to its diagnostication.

THE TREATMENT OF DIPHTHERIA.

In the *Deutsche med. Wochenschrift*, February 2, 1888, Dr. v. Kaczorowski, of Posen, publishes an abstract of a paper on the subject of the treatment of diphtheria, in which he expresses views which we believe to be thoroughly sound. He discusses the nature of this disease, and outlines his own method of treating it. This consists in administering mild purgatives, preferably castor oil, and half tablespoonful doses of a mixture containing two parts of tincture of iodine and five parts of common salt in five hundred parts of water. This dose is to be slowly swallowed every quarter of an hour. He attaches great importance to the effect upon the throat of mild purgatives given every day while the disease is active, and to the local influence of a mild disinfectant solution such as is described above. Chlorate of potash, he believes to be an unsafe remedy; and prefers the combination of tincture of iodine and chloride of sodium, because it is safe, easy to take, and does not interfere with the appetite. It can be used also for washing out the nasal passages when these are implicated. In grave adynamic cases or when the membrane is putrid, he administers camphor and benzoic acid, and alcoholic stimulants, and pays especial attention to the nutrition of the patient, and to securing an abundance of fresh air, even in cold weather.

In regard to medication, Kaczorowski expresses a great horror of mercurials, and especially of corrosive sublimate. His objection to this class of remedies is purely theoretical, however, and we believe it would disappear if he used them scientifically. We think that the purely empiric administration of large doses of calomel at the outset of diphtheria is often of great service. This may be partly due to the fact that it usually produces free catharsis; but it certainly seems to do good even when no catharsis follows its use.

In the main, we think the views of Kaczorowski are correct, and we would especially endorse his deprecation of violent applications to the throat. We believe that there is little occasion for making them, especially in the case of children, who are often needlessly tortured in this way. Much more can be accomplished with teaspoonful doses of lime water, swallowed slowly every hour, than those who rely upon sprays and gargles, and local applications of various salts of iron or of strong acids, or of powerful disinfectants would believe. Keeping the bowels open, we believe to be one of the most important parts of a judicious treatment of diphtheria; and for this purpose we think no drug is better or so easy to administer as calomel in small and frequently repeated doses—for children, one-tenth of a grain, with a grain or two of sugar, given every hour until a stool is passed.

Tonics are rarely needed, but when they are called for, we believe the best to be small doses of whiskey—a teaspoonful every hour or two, for an adult, and correspondingly smaller doses for children—with perhaps a grain or two of quinine three times a day, and a few drops of the tincture of the chloride of iron in glycerine.

These measures, with good hygiene and good diet, will rarely fail to secure a satisfactory result in cases of ordinary severity. It may be pure luck which leads a man like Kaczorowski to think that they can be relied on, as a rule, in the treatment of diphtheria, and he may have had only simple and light cases to treat. But, again, he may not hav

spoiled his cases with too great zeal in treatment, and some of them may have been easy to treat because he did not make them hard.

THE TREATMENT OF TYPHOID FEVER.

In the *Archives Générales de Médecine*, January, 1888, M. Albert Robin has a paper on the treatment of typhoid fever, and the typhoid state in general, which is deserving of the most careful consideration He opposes the current theories in regard to the causes and the significance of high temperature, and the present practice in endeavoring to suppress it. He believes that chemical and physiological investigation does not support the view that high temperature is due exclusively to increased combustion in the body, or to diminished elimination of caloric. For this reason he is opposed to methods which seek simply to restrain the production of heat, or to abstract it rapidly; and he thinks it unwise to give heroic doses of so-called antipyretics, or to push cold baths or cold packing until the temperature falls decidedly. On the other hand, he shows, by a process of reasoning which is so admirable that we regret being unable to reproduce it in full, that more is to be expected from careful regulation of diet, copious supplies of drinking water, abundance of fresh and cool air, and medicines which are antiseptic and promotive of oxidization in the tissues, than from any attempt to combat the temperature alone.

He speaks particularly of the undesirability of trusting to massive doses of quinine, antipyrine, alcohol, and so forth; and inclines to the use of simple eliminants and moderate washings combined with the hygienic measures alluded to above.

In this we wholly agree with him, feeling sure that typhoid fever can be treated satisfactorily without the use of large doses, and especially of large doses of quinine and alcohol. The latter we believe to be absolutely dangerous, and to be only excused, but never justified, by the desperation in which one is apt to fall who sees a patient getting worse instead of recovering, and who thinks that, if a little of a remedy is good, more of it must be better.

Our own conviction is strong, as we have indicated already in an editorial in the REPORTER, December 3, 1887, that the time when a case seems desperate is the very time when the physician should most courageously restrain the natural disposition to fly to desperate remedies. If the patient should die—well, some must die, or man would be immortal! But, he may yet get well; and, we believe the likelihood of this happy issue of the case is materially improved by sticking to gentle measures, and sparing the patient from having to struggle with the influence of violent medicament, as well as with the depressing forces of his disease.

QUACK ADVERTISEMENTS IN RELIGIOUS NEWSPAPERS.

Since the publication of our editorial in the REPORTER for Dec. 31, 1887, on quack advertisements in religious newspapers, we have received a number of letters expressing concurrence with our opinions and sympathy with our endeavor to so direct attention to the subject as to lead to some improvement in the moral tone of these religious guides. Some of these letters come from the editors or publishers of religious papers, and—as might have been expected—from those who do not sin in the way under discussion. Some of these letters bear witness to the hardships which go hand-in-hand with a strict adherence to principle, and to the sense of injustice excited by seeing so-called religious papers, which are blessed with comfortable consciences, waxing fat, while the truthful and honest paper has some trouble in getting along. It is true that the *mens conscia recti* is a good thing to have; but, since the days of Ecclesiastes, those who try to do what is right would like to believe that the sinner was less comfortable without it than he appears to be. But the so-called religious papers which make money out of quack advertisements manifest a bluntness of moral sensibility, which leads some of our correspondents to doubt that anything will arouse them to a sense of their turpitude. We shall see, how-

ever. Our religious contemporaries will not forget that a similar state of affairs led Jonah to think it hardly worth while to go to Nineveh; and it may be that the so-called religious newspapers are not sunk as deep in iniquity, as some of the really religious newspapers seem to think.

Book Reviews.

[Any book reviewed in these columns may be obtained, upon receipt of price, from the office of the Reporter.]

A MANUAL OF MEDICAL JURISPRUDENCE, WITH SPECIAL REFERENCE TO DISEASES AND INJURIES OF THE NERVOUS SYSTEM. By Allan McLane Hamilton, M.D., one of the Consulting Physicians to the Insane Asylum of New York City, etc. With illustrations. 8vo, pp. 390. New York: E. B. Treat, 1887. Price, $2.75.

This book is presented as an elementary treatise and book of reference for lawyers and doctors. None the less, it is much more than the author in his modest preface declares it to be. He discusses in considerable detail, and to an extent indicated by the number of pages the book comprises: Insanity, Hysteroid Conditions and Feigned Diseases, Epilepsy, Alcoholism, Suicide, and Cranial and Spinal Injuries.

The author's established position as a writer on diseases of the nervous system fits him peculiarly for preparing a book on this subject, and those who consult this one will not be disappointed. It is a book which might be studied with profit, not only by practicing physicians, but also by lawyers, to whom problems of medical jurisprudence are presented many more times than they ever are to courts of law. We believe that this subject is one which ought to form part of the education of every doctor and every lawyer, and that no one of these two classes should leave the study of it until the exigencies of a civil or criminal action make it imperative. As our readers are chiefly physicians, we would urge upon them the importance of knowing something about medical jurisprudence, and can recommend Dr. Hamilton's book as both instructive and interesting.

ELEMENTARY MICROSCOPICAL TECHNOLOGY. In three parts. Part I. The Technical History of a Slide, etc. By Frank L. James, Ph.D., M.D., etc. 8vo, pp. 107. St. Louis: St. Louis Medical and Surgical Journal Company, 1887. Price, paper, 50 cents; cloth, $1.00.

The author of this book has been led to prepare it because in his experience, as a student and as a teacher, he had not found any work in which the technical details of microscopical work were not so scattered throughout the departments devoted to micrography as to make them to a certain extent useless to beginners. In order to supply the want which he felt, he has prepared a book in which nothing but technical detail is considered, and which we can heartily commend to beginners in microscopy. This part of his work deals simply with the steps required to prepare a specimen mounted permanently upon a slide, and omits no necessary detail of this procedure. The author's style is clear, and his instructions are entirely trustworthy; and we think that his book is calculated to be of very great service to the class of persons to which it is addressed.

SPINAL CURVATURE, COMPRISING A DESCRIPTION OF THE VARIOUS TYPES OF CURVATURE OF THE SPINE, WITH THE MECHANICAL APPLIANCES BEST SUITED FOR THEIR TREATMENT. By R. Heather Bigg, Assoc. Inst. C.E., etc. Illustrated by the author with numerous pen and ink drawings. 8vo, pp. 128. London: J. & A. Churchill, 1882. Price, $1.00.

This book is not new, but it comes newly to our table. It contains plain and practical instructions as to the nature and proper treatment of the different varieties of curvature of the spine, both those dependent upon alterations in the bones and those due to nervous and muscular defects. It is marked by evidence of good common sense, and we believe is a safe guide in the matter of which it treats. It will interest Americans to know that Mr. Bigg strongly opposes the view that the plaster-of-Paris jacket of Sayre is a panacea for spinal curvatures, and that he goes so far as to assert that, when it is the best appliance for any given case it need not be applied with the aid of suspension. These opinions are not so singular now as they were when Mr. Bigg first made them public; but it is interesting to note the plainness with which he states them, and the fairness with which he maintains them.

Pamphlet Notices.

I. An Address from a Special Committee of the College of Physicians of Philadelphia to the Medical Societies of the United States, Concerning the Dangers to which the Country is Exposed by the Ineffectual Methods of Quarantine at its Ports, and in Regard to the Necessity of National Control of Maritime Quarantine.

II. Report of the Committee of the College of Physicians of Philadelphia, Appointed to Investigate the Efficiency of our Quarantine Arrangements for the Exclusion of Cholera and other Epidemic Diseases. *Printed for the College*, 1888. 45 pp.

The Galvano-Cautery Sound and its Application, Especially in Hypertrophy of the Prostate, with Reports of Cases, by Robert Newman, M.D., of New York. From the *New England Medical Monthly*. 53 pp.

The Structure of White Thrombi. By W. H. Welch, M.D., Baltimore, Md. From the *Transactions of the Pathological Society of Philadelphia*, vol. xiii, 1887. 22 pp.

—We have already, in the Reporter, Dec. 24, 1887, published the address of the College of Physicians of Philadelphia to the Medical Societies of the United States, and need not further commend it to our readers. The second part of the pamphlet before us, although it antedated the first, furnishes an interesting and instructive appendix to this, and deserves to be carefully studied in connection with it.

—Dr. Newman's paper, which he read at the Ninth International Medical Congress, contains a strong argument for the use of a galvano-cautery which he has devised in the treatment of enlargement of the prostate gland, supported by accounts of

eight cases in which he has used it, introduced through the urethra or after a supra-pubic cystotomy. The reason for Dr. Newman's enthusiastic faith in this method is that, in his experience, "it has benefitted or cured all cases under observation; a reasonable time has passed without any relapse; it has caused no pain, no detention from business or pleasure; no untoward after symptoms or circumstances have ever occurred."

—Dr. Welch's paper contains an admirable summary of the literature of the subject of white thrombi, together with critical remarks upon it, and an expression of his own views in regard to their structure and mode of formation. These views are founded in part upon the results obtained by other observers and experimenters, and in part on his own observation and experiments. He assigns a very important part, in the formation of white thrombi, to the "hæmatoblasts" of Hayem, called also "blood-plates" by Bizzozero, and "blood-plaques" by Kemp and by Osler. The discussion of this subject is too recondite to permit a satisfactory brief analysis of it, and we must refer our readers to Dr. Welch's paper for information as to the present state of knowledge in regard to it.

Literary Notes and Queries.

[In this column the Reporter will publish short items of literary interest and questions addressed to this Journal or its readers, and answers to them, in regard to any literary matters: books, authors, places and prices of publications, etc.]

—Lea Brothers & Co., Philadelphia, announce the preparation of a *Clinical Atlas of Venereal and Skin Diseases*, by Robert W. Taylor, A.M., M.D. It is to be published in eight imperial folio parts, with 58 full-page chromo-lithographic plates, containing 191 figures. Price, per part, $2.50, to be sold only by subscription.

Correspondence.

Quack Advertisements in Religious Newspapers.

[We publish some of the letters received from our contemporaries in response to the Editorial of December 31, 1887, on this subject, selecting the first that came in chronological order.]

The Churchman (Protestant Episcopal.)
New York, Jan. 16, 1888.

Editor Med. and Surg. Reporter:

Sir:—The enclosed clipping is sent to us from one of our subscribers. Will you kindly inform us if it refers in any way to the *Churchman?* And oblige,

Yours truly, M. H. Mallory & Co.

[To this we replied: "The part of the editorial quoted which refers to the *Churchman* is that which contains the statement, "There are a few happy illustrations of the fact that, even in a religious newspaper, 'honesty is the best policy.'"

The Church at Home and Abroad. (Presbyterian.)
Philadelphia, Feb. 4, 1888.

Editor Med. and Surg. Reporter:

Sir:—I fully sympathize with the views you express about quack advertisements; but as our magazine does not advertise at all, it is probable that our contemporaries would not much heed what we might say.

Yours truly,
H. A. Nelson, Editor.

The Christian Register (Unitarian).
Boston, Feb. 4, 1888.

Editor Med. and Surg. Reporter:

Sir:—We shall be glad to print your article on quack advertising in religious newspapers. The *Register* has not published any such advertisements for years. It has lost thousands of dollars by pursuing this course. Still, we believe with you that our duty to the public requires it.

Yours truly,
Samuel J. Barrows, Editor.

The Church Record (Protestant Episcopal).
Southport, Conn., Feb. 4, 1888.

Editor Med. and Surg. Reporter:

Sir:—When the *Church Record* was started, about three years ago, it placed at the head of its columns and on all advertising circulars and slips, "No Patent Medicine Ads. Received." * * * We knew that there were remedies patented which were good and useful, but we were not qualified to judge between them, and even the best are not desirable for indiscriminate use. Therefore, we were fixed in our position. We believe we are the only general religious paper in the land which from start to the present time has maintained this position. We have done it at great financial loss and in the face of personal abuse, but we shall do it to the end.

Whether we agree with your editorial or not, you can judge from this. And we hold that publication of medical ads. is not a matter of taste or business management, but a direct iniquity. You may use this letter as you think best.

Yours truly,
C. G. Adams, Editor.

The Moravian.
Bethlehem, Pa., Feb. 4, 1888.

Editor Med. and Surg. Reporter:

Sir:—I beg to state that for upwards of a year *The Moravian* has declined to insert any advertisements of proprietary or quack

medicines, at considerable financial loss, but to the very great satisfaction of

Yours truly, EDWIN G. KLOSÉ,
Editor and Publisher.
Freethinkers' Magazine.
Buffalo, N. Y., Feb. 4, 1888.

EDITOR MED. AND SURG. REPORTER:

Sir:—I beg to differ with you. I consider that religious journals are precisely the ones that should publish these advertisements. That is the proper place for them. Religion is nothing but quackery. The class of papers that they should be kept out of is the scientific and free-thought papers, that advocate what is known to be true. There should be nothing but quack advertisements in the religious newspapers.

Yours truly, H. L. GREEN,
Editor and Publisher.

Some new Uses for Antipyrin.

EDITOR MED. AND SURG. REPORTER:

Sir:—Deeming any new use for an old drug equal in value to the discovery of another drug, I offer my conclusions as to the uses of antipyrin. As to its well-known efficiency and safety as an antipyretic in typhoid fever and pneumonia, I cannot speak too highly. Perhaps its uniformly pleasing effect in my hands has been due to the fact that I never give larger doses than 10 grains, repeating this dose in one or two hours, if necessary.

In an epidemic of typhoid fever in Imlaystown, N. J., I have used it with uniformly good results in twenty-one cases, in which the temperature rose above 103°. Most of the parties to whom I give antipyrin speak of the relief it has given them, which is good evidence of its beneficial action. I find many cases of dysmenorrhœa which can be relieved in thirty minutes with doses of 3 to 5 grains of antipyrin, repeated as may be required by recurrence of the pain. I will cite only one case in point: E. N., 32 years old, married, no children, has for twelve years been compelled to keep her bed or a lounge for two days at every menstrual period. She is now able to be around all the time, and suffer no pain, by taking 4 grains of antipyrin whenever she feels the pains coming on. Previously, the only relief was obtained from opium and belladonna suppositories, which did not relieve the nausea and vomiting accompanying the pain as the antipyrin does; and, besides, caused the patient to keep quiet another day after the pain had ceased, in order to recover from the effects of the opium.

I have also found the drug useful in cases of trigeminal neuralgia, of which I have notes of two typical cases. In the first case, a man 50 years old, suffered with neuralgia of the first division of the fifth nerve, and was for a while benefitted by quinine and opium, as usually administered. Finally this lost all effect, except that it still produced ringing in the ears. Subsequently, potassium iodide in drachm doses at bedtime seemed useful for a while; but it did not agree well with the stomach. At last I tried antipyrin, and have been able to relieve the neuralgia every time it has recurred since (for six months), with five grain doses given every six hours until he is relieved.

Another very obstinate case of neuralgia of the first branch of fifth nerve occurring in a woman 70 years old, who has been a great sufferer all her life, I find invariably relieved by four grain doses of antipyrin every six hours, until sleep occurs, which is the signal of recovery. She is often unable to sleep for five or six days and nights from the terrible agony, which opiates seem nearly powerless to relieve owing to the length of time she has used them. This patient, having tried so many "specifics," had no faith in any new drug; but, since trying antipyrin, is very careful not to get out of "headache powders." H. G. NORTON, M.D.

Imlaystown, N. J.

Chewing and Swallowing Glass.

EDITOR MED. AND SURG. REPORTER:

Sir:—Several months ago a negro-man, named Bill Jones (and I have no doubt it is the same man to whom Dr. Gracy alludes: REPORTER, January 14, 1888, pp. 61 and 62), registered with Kohl and Middleton of this city, the well-known Dime Museum proprietors, they advertising him as "The Greatest Phenomenal Glass-Eater of the Age." He bore the impress of perfect health, and acknowledged frankly, and, I believe, conscientiously, that he had at no time suffered from indigestion or any form of gastric disturbance. I may venture to say, without any degree of hyperbole, that one-half of the people of Chicago saw Jones perform the novel feat of chewing and swallowing glass, the majority of them believing, as may naturally be expected, that it was a sleight-of-hand performance. He disposed of a portion of a lamp chimney every hour for the benefit of the spectators, as it is a rule, I understand, for the Museum to change its audience every hour. Jones was billed for a three weeks' engagement at this Museum, during which

time he ate, according to Mr. Kohl's statement, on an average of two lamp chimneys a day, which would make a total, with the three Sundays included, of forty-two. His novel feat having become more generally known through its dissemination at large by the thousands of spectators that witnessed the performance, as well as extensive advertising, some physician suggested the practicability of calling on Mr. Kohl and asking his permission to exhibit Jones before a body of scientific, medical men to see whether or not it was a purely sleight-of-hand performance, or a typical case of glass-eating. Permission was granted, and Jones was subsequently taken to the Rush Medical College and there exhibited before a class of five hundred students, as well as several professors. Jones devoured with seemingly great gusto every particle of a lamp chimney which was brought into the lecture-room, the physicians in attendance watching every movement he made to see that it was not a pseudo-stomachic feat. A second one was ordered, which he ate with as much relish as the first. After disposing of the second, some one suggested another kind of glass, which was much thicker and of a blue color. Jones objected on account of the thickness of the glass, its color, and bitter taste, claiming that his stomach was peculiarly sensitive and would rebel against any kind of glass other than lamp chimneys, which he characterized as being "very sweet." After devouring the second lamp chimney, a probang was introduced and he vomited particles of the glass, which were slightly streaked with blood. The probang, however, was introduced more as a means to prove that the man *actually swallowed* the glass than for its well-known practical purpose of removing foreign bodies from the throat. One of the students procured another (a third) chimney, and urged Jones to dispose of that, to which he replied, "I do not like to overload my stomach now, as I have to eat one or two chimneys at the Museum to-night for the benefit of the spectators." *He actually eats the glass and discharges it from the bowels in the same state as when swallowed.* I have seen two other public performers eat glass, but not in such large quantities. Every one present regarded it as a *bona fide* case.

WILLIAM WHITFORD, M.D.
146 Warren Avenue, Chicago.
Feb 7, 1888.

Correction.

The first prescription in Dr. Bundy's letter (REPORTER, Feb. 11, 1888, p. 185,) should have contained: Dilute phosphoric acid, 8 fluid oz.; compound fl. extract of cinchona, 2 fluid oz. The prescription as a whole would then read:

Take: Sulphate of strychnine.....4 grs
Dilute phosphoric acid.....8 fluid oz
Comp. fluid ext. cinchona.....2 " oz
Madeira wine.....1 pint
Simple syrup.....6 fluid oz

Yours truly,
A. D. BUNDY.

St. Ansgar, Iowa.
Feb. 14, 1888.

NOTES AND COMMENTS.

The Scarlet Fever Germ.

The *St. James' Gazette* (London) has recently published an interesting account of the experiments of Dr. Klein and Mr. W. H. Power, of the Medical Department of the Local Government Board, in regard to the relation between a disease found on the udders of some cows at Hendon and scarlatina. The cow disease was not itself scarlatina, but by cultivation of the organisms obtained from cows the specific micrococcus of scarlatina was produced. Moreover, this cultivation was made in milk, and it was the milk of the affected cow that caused the scarlatina epidemic which gave rise to the inquiry. Then it was proved that the virus of the cow disease, if conveyed into the human body by the medium of milk, developed there into the germ of scarlatina; although between the cow disease itself and scarlatina there is almost every possible difference. This discovery suggested to Dr. Klein a further question. He had shown that the cow disease could set up scarlatina in the human subject; he would now find out whether the scarlatina germ was capable of producing the cow disease.

From a number of patients in the Fulham Fever Hospital Dr. Klein took minute quantities of blood. These were placed in tiny tubes, and transferred to the surface of nutritive gelatine. In the result he obtained clear evidence that in some of his experiments the blood contained organisms. In other cases no positive results whatever were obtained. But in four cases out of nine the specific organism was detected; and the organism so recovered from the blood of scarlatina patients was found to be exactly the same as has been cultivated from the virus taken from the teats of the Hendon cows. Dr. Klein does not hesitate to name this organism the micrococcus scarlatinæ, as having

a special character and a definite mode of existence. The next question was whether, itself capable of being cultivated from the cow disease, it was capable of being transformed back into the virus of that disease.

With a subculture of micrococcus scarlatinæ derived from scarlet fever in a human being Dr. Klein inoculated two calves. The first was killed after ten days, and from blood taken from it a growth was derived identical with the micrococcus scarlatinæ. The second calf was killed after twenty days, with the same results. In both animals an identical disease had been produced. Subsequently two calves were fed with milk mixed with the growth from several tubes of the same date and the same source as used for the other calves; and again the identical disease was produced; this disease bearing a great resemblance to that observed in the Hendon cows, except that there was no affection of the skin. But three out of four other calves —two of which were inoculated and two fed—were differently affected. Sore patches appeared and the skin became scurfy; and on each nostril of one of them there was a patch of eruption which decided the matter. From these skin eruptions were obtained "beautiful chains of cocci" coinciding with those developed from the virus of the cows. The circle was thus complete. A cow disease which is not scarlatina, nor anything like scarlatina, causes the animal to have sore teats. The exudations find their way into the milk-pail, and there develop into something which infects human beings with scarlatina. From the scarlet fever patient a few drops of blood are taken, and after the disease germ has been cultivated, it is passed into the system of a calf, which forthwith becomes attacked by the identical disease observed in the original cow.

But this is not all. A case of suspected condensed milk was brought under Dr. Klein's notice. Scarlatina had broken out, and could be traced to no other source. Sure enough, the micrococcus scarlatinæ was found in the milk, and experiments with it on animals yielded exactly the same results as before. Again, last January, a monkey died at Wimbledon of scarlatina contracted by drinking the milk of cows among which there prevailed a disease similar to that at the Hendon farm. Microscopic examination of the internal organs of the monkey revealed the same changes as occur in these organs in human scarlatina, and in the blood the scarlatina micrococcus was found. By means of this micrococcus the Hendon disease was again induced in animals. Dr. Klein may therefore claim to have discovered a hitherto unsuspected cause of scarlatina, in the form of a little noticed and less understood cow disease, quite distinct from the dreaded malady which—after certain developments of its germ—it produces in man.

Material for Pessaries.

Dr. Ernest Fränkel, of Breslau, in the *Illustrirte Monatsschrift der Aerztl. Polytechnik*, Jan., 1888, speaks of the great value, in the treatment of retroflexion of the uterus, of Thomas's pessary. He describes the drawbacks of hard rubber as a material for their construction, and a plan which was carried out for him by Härtel, of Breslau, of making them of glass. The only objection to this material is that it is heavy, and Fränkel suggests that the pessaries might be made hollow, so as to be lighter, without impairing their strength.

He also strongly commends the use of pessaries made of copper-wire, covered with celluloid, as being less liable to incrustration, less liable to change shape when exposed for a long time to the temperature of the body, and demanding less skill to adapt their shape to the requirements of individual cases.

The Sense and Senses of Animals.

Sir John Lubbock recently devoted a lecture to this subject in Green Street Hall, Edinburgh, and pointed out that the dog was generally admitted to be a loyal, true and affectionate friend of man; but, when the nature of the animal was considered our knowledge, he said, was very limited. This arose from the fact that attempts were made to teach animals rather than to learn from them. It had occurred to him that some such method as that which was followed in the case of deaf mutes might prove instructive if adapted to the case of dogs. He had tried, with a black poodle belonging to himself, and had made the following experiments: "He had taken two pieces of card, one blank and the other with the word 'food' upon it. He had put the latter on a saucer containing some bread and milk, and the blank card he put on an empty saucer. The dog was not allowed to eat until he brought the proper card to him. This experiment was repeated over and over again, and in about ten days the dog began to distinguish the card with the letters on it from the plain card. It took a longer time to make the dog realize the difference between different words. In order to try to discover whether

the dog could distinguish colors, he prepared six cards, marking two of them blue, two yellow and two orange. He put one of each on the floor, and tried to get the dog to bring to him a card with the same color as one which he showed the dog in his hand. After trying this for three months, he found that his experiment in this direction was a failure." Sir John Lubbock proceeded to state that he considered it doubtful whether ants could hear or not, but that it was possible that both they and bees might hear sounds so shrill as to make no impression on the human organ of hearing; and so perhaps with colors. The world might, to insects, be full of music which we could not hear, colors which we could not see, and sensations which we could not feel.—*Lancet*, Dec. 31, 1887.

A Cunning Malignerer.

L. M. Logan, who was arrested two months ago at Alton, Ill., on the charge of swindling, has meanwhile been swindling some eminent physicians out there. He was taken with a remarkable illness, which was finally diagnosticated as a tumor, or abscess, of the brain. To the mortification and disgust of the surgeons, he gave up shamming recently, and explained with frankness how he had dilated his eyes with belladonna, brought on vomiting by swallowing tobacco-juice, increased his pulse by striking his elbow against the wall, and brought on palpitation of the heart and blood-rushes to his face by forcing air into his lungs while he contracted his chest. He also had frequent but bogus fits, but will now catch genuine ones from the jail authorities.—Philadelphia *Ledger*, Jan. 24, 1888.

Treatment of Pistol-shot Wounds.

Dr. Paul Reclus, surgeon at the Hôtel-Dieu, Paris, in a recent volume (*Cliniques chirurgicales de l'Hôtel-Dieu*), expresses himself strongly against exploring for a ball after a wound from a pistol. He says the object of the surgeon in these cases should be, not to extract the ball, but to repair the damage done by its passage; and that "in every simple pistol-shot wound it is usually not the ball which brings danger, but the surgeon with his ill-judged manœuvres."

A Model Children's Ward.

A new ward intended for children only has just been finished at the Presbyterian Hospital, in Philadelphia, being a gift to the hospital from Mrs. John Wanamaker, in memory of her mother, Harriet Eminger Brown. The ward was formally opened January 30. The following description indicates the points in which the construction of the building differs from what is customary in hospital wards:

The new ward is a two-story structure of brick and terra-cotta, with granite window sills and entrance steps. The building *is octagonal in form*, and the ground floor has a diameter of fifty two feet, and a clear height of fifteen feet. This is the main ward, and contains eighteen beds, ranged around the wall so as to face the centre. Two large open fire-places are in the centre of the room, and connect with the main ventilating shaft, which extends through the second floor and roof to the open air, where it is encased in terra-cotta work. The ward will be heated by steam pipes upon the ceiling of the basement. The walls, to a height of about ten feet, are wainscoted with encaustic tiles of various colors, and the remaining distance is plastered and finished with a hard coat of lime and sand. The windows open directly upon a porch which surrounds the building.

The second floor runs a clear height of thirteen feet. The southern half will be used as a play-room and the northern half will be utilized for the treatment of special cases. The walls of the vestibules, entrance ways, offices, etc., are finished in enamelled brick.

Dreadful Result of Carelessness in a Hospital.

At the Roosevelt Hospital, in New York, on January 31, an orderly was ordered to move a patient named Charles McClane from the second to the third floor of the hospital, where the doctors were about to perform an operation upon him. The orderly raised the elevator to the second floor and went for the patient. Having placed him in a rolling cot, the orderly moved him to the shaft, reopened the door, and, without looking to see if the elevator was there, rolled the cot forward. During the orderly's absence to prepare the patient the elevator had been sent up a story, and the patient was precipitated through the shaft down to the cellar. He was picked up and removed as carefully as possible, but died during the evening from the injuries received during the fall.

Vulvo-Vaginitis of Little Girls.

Small suppositories, about a quarter of an inch in diameter, containing each from two to four grains of iodoform, inserted in the vagina, are said by Dr. R. Potts to produce a rapid cure of vulvo-vaginitis in scrofulous children.

Benzoate of Sodium in Acute Follicular Tonsillitis.

L. C. Boisliniere, Jr., in a communication to the *St. Louis Courier of Medicine*, February, 1888, says that in upwards of one hundred cases of acute follicular tonsillitis, the following formula has been used:

Sodii benzoat.....3i–iv
Glycerini,
Elix. calisayæ.....āā f℥j
M. Sig.—One teaspoonful every one or two hours.

In the analysis of the last seventy-five cases, he finds that: 1. By the use of benzoate of sodium the disease is cured in from twelve to thirty-six hours, a great gain in time, as the average duration of the disease has been heretofore from two to five days. The average duration for the seventy-five cases was twenty hours. In private practice, when the cases could be watched more carefully, the white cheesy points have been frequently seen to disappear in from eight to ten hours. 2. The benzoate of sodium undoubtedly controls the febrile elements in the disease. 3. It may be given with impunity, even to children; he has never been able to discover any bad or even disagreeable effects from its action. 4. It is a valuable addition to the remedies used in throat affections, especially in an acute inflammatory condition of the tonsils, when applications only aggravate, and gargles increase the trouble.

Hyperidrosis.

In an article on hyperidrosis, or excessive sweating, published in the *Journal of Cutaneous and Genito-Urinary Diseases*, February, 1888, Dr. C. W. Cutler gives the following as the causes of the disease and the course to be pursued in its treatment: 1. The cause is usually a nervous one. 2. The secretion of the sweat glands seem to be controlled by the sympathetic ganglions or system of nerves. 3. The hyperidrosis is a functional affection of the sympathetic system. 4. The sweating of the extremities is usually symmetrical owing to the close relationship and anastomosis of the sympathetic ganglions of the trunk; and asymmetrical on the head and neck for want of this relationship. 5. There is but slight structural change in the affected sweats glands, and such as exists is accounted for by the hyper-secretion; the disease is probably functional and not organic. 6. The difference in appearance of the affected skin on the extremities and trunk is due to the distance from the centre of circulation, as the physiological conditions are the same. 7. Painful and tender feet, not rheumatic, are usually the result of hyperidrosis. 8. Bromidrosis is usually the result of uncleanliness — not removing the secretion promptly. 9. Nerve tonics are usually indicated in the treatment of hyperidrosis. 10. Local treatment is always indicated, and although it may not effect a cure, it nearly always relieves the symptoms.

A Queer Prescription.

The London correspondent of the *Irish Times* says: I had it yesterday, from one of the counsel retained in the case, that a very curious litigation is listed for hearing during the present term. Some two years ago a North London doctor, having a large family practice, had on his list of patients a lady long suffering from an affection of the face and jaw which baffled the arts of the faculty. She had been for some time under his care when she changed her residence from London to Newcastle-on-Tyne, but kept herself in the hands of her London doctor by letter. Finding the ailment obstinate and the patient somewhat intractable and hypochondriacal, the doctor wrote, in the end, saying he had exhausted his resources, and adding his opinion that the *edax rerum* was the only remedy. The dead language was matter in the wrong place. It proved a snare, for the lady hied herself to a local chemist, and applied for the specific as set forth in the letter. The attendant—it will be contended, through deliberate dishonesty—made up a bottle, for which he charged one dollar, and at the patient's request registered, or pretended to register, her name in the shop-book as a customer to whom the remedy was to be regularly supplied. She continued using and paying for the sham medicine for over a year and a half; and a curious point in the case will be her admission that it gave her more relief than any previous remedy employed. Coming to London for the Royal Jubilee, she chanced to meet her former doctor, who, it should be said, had told her in his letter that, being unable to do more for her, he did not feel justified in continuing the correspondence. He was astonished to find himself gratefully thanked for his final advice, and still more astonished when the lady related the facts. He wrote at once for an explanation, and advised the patient to demand the return of the large sum she had paid in fancy prices for the nostrum. The next stage of the business began with the disappearance of the assistant and the denial of any responsibility on the part of the chemist. On these main facts the case is based, but some re-

markable revelations of the human capacity for consuming doctor's stuff may be expected. The plaintiff has, it seems, been an invalid from her twentieth year, and has for the quarter of a century intervening paid for medicine alone ten thousand dollars."—*Chemist and Druggist*, Feb. 4, 1888.

Creolin in Cystitis.

The *Lancet*, Jan. 14, 1888, reports a very persistent case of cystitis occurring in a middle-aged woman, in which the pain was so constant that the patient was generally obliged to keep her bed, and in which the urine was very offensive, brownish and thick, depositing a third of its volume of pus, blood, and phosphates. After a number of different kinds of treatment had been employed by various medical men without much result, Dr. Jefsner, of Stolp, washed out the bladder with a ½ per cent. solution of creolin. This caused a burning sensation for a few minutes, after which it passed off. The next day the patient felt and looked quite a different woman, the pain in the bladder was less, and the urine much less offensive. The washing out of the bladder was repeated daily, and by this means the improvement was maintained.

American Medical Association.

The Thirty-ninth Annual Session will be held in Cincinnati, Ohio, on Tuesday, Wednesday, Thursday and Friday, May 8, 9, 10 and 11, commencing on Tuesday, at 11 A.M.

"The delegates shall receive their appointment from permanently organized State Medical Societies, and such County and District Medical Societies *as are recognized by representation in their respective State Societies*, and from the Medical Department of the Army and Navy, and the Marine Hospital Service of the United States.

"Each State, County, and District Medical Society entitled to representation shall have the privilege of sending to the association one delegate for every ten of its regular resident members, and one for every additional fraction of more than half that number; *Provided*, however, that the number of delegates for any particular State, territory, county, city or town shall not exceed the ratio of one in ten of the resident physicians who may have signed the Code of Ethics of the Association."

Secretaries of medical societies, as above designated, are earnestly requested to forward, *at once*, lists of their delegates.

Also, that the Permanent Secretary may be enabled to erase from the roll the names of those who have forfeited their membership, the Secretaries *are, by special resolution*, requested to send to him, annually, a corrected list of the membership of their respective societies.

The officers of Sections are as follows:

Practice of Medicine, Materia Medica and Physiology: Chairmanship vacant; *Secretary*, Dr. N. S. Davis, Jr., 65 Randolph St., Chicago, Ill.

Obstetrics and Diseases of Women ana Children: Chairman, Dr. Eli Van De Warker, 45 Montgomery St., Syracuse, N. Y.; *Secretary*, Dr. E. W. Cushing, 1 Hotel Pelham, Boston, Mass.

Surgery and Anatomy: Chairman, Dr. Donald McLean, 72 Lafayette Avenue, Detroit, Mich.; *Secretary*, Dr. B. A. Watson, 124 York St., Jersey City, N. J.

State Medicine: Chairman, Dr. H. B. Baker, Lansing, Mich.; *Secretary*, Dr. S. T. Armstrong, U. S. M. Hosp. Service.

Ophthalmology, Otology and Laryngology: Chairman, Dr. F. C. Hotz, 181 Clark St., Chicago, Ill.; *Secretary*, Dr. Edw. Jackson, 215 S. 17th St., Philadelphia, Pa.

Diseases of Children: Chairman, Dr. F. E. Waxham, 3448 Indiana Ave., Chicago, Ill.; *Secretary*, Dr. W. B. Lawrence, Batesville, Ark.

Oral and Dental Surgery: Chairman, Dr. J. Taft, Cincinnati, Ohio; *Secretary*, Dr. E. S. Talbot, 125 State St., Chicago, Ill.

Medical Jurisprudence: Chairman, Dr. E. M. Reid, 243 N. Fremont, St., Baltimore, Md.; *Secretary*, Dr. C. B. Bell, Suffolk, Mass.

Dermatology and Syphilography: Chairman, Dr. E. D. Bulkley, 4 E. 37th St., N. Y.; *Secretary*, Dr. S. F. Dunlap, Danville, Ky.

A member desiring to read a paper before a Section should forward the paper, or its *title* and *length* (not to exceed twenty minutes in reading), to the Chairman of the Committee of Arrangements at least one month before the meeting.

Committee of Arrangements. — W. W. Dawson, Cincinnati, Ohio, *Chairman.*

Permanent Secretary.—Wm. B. Atkinson, M.D., Philadelphia.

Diphtheria.

Simon recommends (*Revue de Clinique et de Thérapeutique*):

℞ Acidi salicylici ..... gr. viij
Olei eucalypti ..... f℥ij
Glycerini ..... f℥viiss
Alcohol ..... f℥iij
Mix. Sig.—For local use, every hour.

Prizes.

The *Western Druggist* offers the following prizes:

First prize—One hundred dollars—for the best apparatus driven with power for the purposes of comminution, trituration, etc.

Second prize—Fifty dollars—for the best apparatus for continuous extraction with volatile solvents.

Third prize—Twenty-five dollars—for the best design for shop furniture for laboratory or other working purposes.

Fourth prize—Fifteen dollars—for an apparatus possessing the greatest improvements over any of the devices at present in use for compressing, coating or filling, pills, tablets, lozenges or capsules.

Fifth prize—Ten dollars—for the most simple and economical plan for fileing prescriptions.

Notes on a Recent Epidemic of Erysipelas.

Dr. G. Greene, Medical Health Officer for Ferns, reports, in the *Medical Press and Circular*, Dec. 21, 1887, that, during the months from August to November, Ferns and the surrounding district has been visited by a rather severe epidemic of erysipelas of a highly contagious nature, forty persons being attacked within a radius of three miles. The disease only affected usually the face, head, and one side of the neck, or both back and front of the chest, together with the upper extremity of the same side. The latter was the rarer but more fatal form, as it was almost invariably accompanied by double pneumonia with a pleural effusion, which also generally affected the left side. Seven, out of the nine cases affected as just described, proved fatal from exhaustion, notwithstanding all efforts made to arrest the course of the disease. There was partial paralysis of the arm in each instance. The attack lasted in mild cases seven or eight days, and in grave ones extended to five or ten weeks. The primary origin was, he believes, largely due to climatic influences; after some isoloted cases had occurred sporadically, it immediately manifested its contagious nature by attacking those in attendance or those in its vicinity. In no instance were there any abrasions of the surface in those catching the disease, nor were the original cases of traumatic origin. In the majority of cases which came under his observation, pneumonia in one or other of its forms preceded or followed the development of the erysipelatous inflammation.

As regards treatment, the author asserts that he found tincture of the chloride of iron worse than useless; while aconite and belladonna acted well in some instances by aborting the attack and curing the intercurrent pneumonia. Quinine proved useful where neuralgia was severe, and creasote when there existed much gastric disturbance. Acid tartrate of potash freely given at the outset, with flour (warmed and browned) externally applied, seemed to give the most satisfactory results in simple uncomplicated cases; whilst tincture of aconite in minim doses every third hour scored the greatest number of rapid cures where pneumonic complications existed.

The clinical value of the author's statements is rendered doubtful by his assertion that aconite and belladonna aborted the erysipelas and cured the intercurrent pneumonia.

A Chinese Doctor and His Fees.

The new district magistrate of Shanghai has taken the native doctors in hand. Lately, he sent one of his messengers to a well-known doctor, with a fee of 600 cash—about 60 cents—to ask him to visit a patient. As the messenger had strict orders not to say he came from the magistrate, the doctor was under the impression that the patient was not an official, and accordingly refused to go. Again the messenger was sent, and again the doctor refused to attend, saying the fee was too small, and that he would not go for three times the amount. The third time the magistrate sent his own card, and the doctor at once hastened to see him. On being interrogated why he had not come in the first instance, he made various excuses, which the magistrate cut short by observing that in future he would cut down the doctor's fees to such a low figure that it would not be worth his while to continue practicing. He gave the doctor the alternative of paying 5000 teals ($6000) to the Yellow River fund. The fine was ultimately reduced to 3000 teals, and the doctor, it is recorded, was very glad to get off so easily.—*London Times.*

Methylal.

Dimethylether of methylene, or methylal, is a soporific of very recent date. It is administered in doses of twenty to twenty-five grains in water, with a little syrup:

Methylal	℥j
Syr. orange flower.	f ℥ss
Water	f ℥j

Mix. Dose—One tablespoonful.

—*Quarterly Therapeutic Review*, January, 1888.

Insanity and Death from Fright.

It is reported from Foxburg, Pa., that a boy 12 years old, named Levi Kahl, the son of a farmer of Elk township, died on Saturday, January 14, from the effects of a fright given him a week before by some boys of the neighborhood. On the road leading from the village church to the Kahl farm there is a lonely spot in the woods where a murder was committed some years ago. At intervals stories of ghosts having been seen by persons passing the spot are told, and the locality has long been dreaded by superstitious people. On Sunday, January 8, the boy was on his way home late in the afternoon, and when it was growing dark in the woods at the alleged haunted spot. As he was passing the spot he heard a noise behind him, and turning around he saw something that he afterward, in semi-sane intervals, described as a ghost, with a head covered with many horns, jump out of the woods into the road, followed by two other figures. Two reports like pistol shots were heard, and the two figures that appeared with what the boy thought was a hideous demon fell to the ground and writhed as if in agony, while they gave vent to unearthly shrieks.

The Kahl boy fled in terror, pursued by the apparition, which followed him almost home. When he entered the house he was in such a state of nervous excitement that he fell into convulsions. He never fully recovered his mind, and his sufferings were intense up to the time of his death. Three boys, acquaintances of young Kahl, have confessed that they masqueraded at the place in the woods for the purpose of playing a joke on him by frightening him. One of the boys had fastened to his head an old tree stump, with tangled roots, which had seemed like horns to the terror-stricken victim.

Resection of the Liver.

An interesting case of removal of part of the liver is reported by Langenbuch (*Deutsche med. Wochenschr.*, Nov. 24, 1887). The patient had complained for eight years of severe pain in the abdomen, with evidence of a tumor. An exploratory incision was made, when it appeared that the tumor was that part of the liver to the left of the gall bladder, which had been separated by tight-lacing from the rest of the organ. Langenbuch ligatured the ligamentous band in several places and removed the lobe, and, although consecutive hemorrhage made a second opening of the abdomen necessary, a perfect recovery followed.

NEWS.

—It is announced that the small-pox, which was recently epidemic in Tasmania, is now completely stamped out.

—A proposal is now before the Senate of the University of Cambridge, England, to admit women to university degrees.

—Mr. George Godwin, who died recently in London at the age of 73 years, was one of the earliest advocates of sanitary science in Great Britain.

—Owing to the scarcity of doctors in Roumania, itinerant practitioners are said to b[illegible] a d[illegible] i l[illegible]

—The *British Medical Journal*, Feb. 4, 1888, announces that on January 24, the fees for the degree of M.D. at Oxford, England, which were formerly about two hundred dollars, were reduced to about one hundred and twenty-five dollars.

—A local epidemic of trichinosis is said to exist in Cunewalde, near Liebau, in Silesia. The disease is attributed to the use as an article of food of small smoked sausages, some of which were found on examination to be full of trichinæ.

—By a decision rendered in the United States Circuit Court of New Jersey, the claim of the Albany Chemical Company is sustained, and the validity of their patent for the manufacture of chloroform from calcium acetate is established.—*Phar. Record*, January 15, 1888.

—A series of evening lectures on special subjects, to be given by the faculty of the Philadelphia Polyclinic at the College building, Broad and Lombard Streets, is announced. Dr. Leffmann will open the course on Feb. 28; *subject:* Office-testing of urine. Members of the profession are invited to be present.

—The *British Medical Journal* suggests that Dr. Heneage Gibbes, who has recently come from London to occupy the Chair of Physiology in the University of Michigan, may be obliged to return to England on account of the peculiar provisions of the law against importing foreigners under contract to perform labor or service in the United States.

HUMOR.

THE PRESCRIPTION CLERK generally gets the drop on everything.

MAGISTRATE:—"Have you no written document to prove that your wife is really dead?"

Peasant: "I have the doctor's bill."—*Fliegende Blätter.*

A LAY CONTEMPORARY not long ago amused its readers with the following joke: As soon as the German Crown Prince was "given up" by the doctors he began to grow better. This shows that the doctors can cure a man if they only go about it in the right way.

YEARS AGO the *Seneca Falls Courier* published an amusing sketch about Horace Greely, called "a story for children," in the course of which it remarked: "The *New York Tribune* had a great many subscribers. A subscriber is a person who takes a paper, and he tells everybody else that he ought to subscribe. After he has subscribed about seven years, the editor writes to him and asks him to let him have $2.50 (two dollars and fifty cents), and the subscriber writes back to the editor and tells him not to send his old paper any more; for there is nothing in it. And the poor editor goes and starves some more."

OBITUARY.

H. T. CLEAVER, M.D.

Dr. H. T. Cleaver, of Keokuk, Iowa, died on January 11, 1888.

W. B. FARNHAM, M.D.

Dr. William B. Farnham, of Chicago, died in that city in the first week of February, 1888.

JAMES E. KING. M.D.

Dr. James E. King, one of the oldest physicians in Buffalo, N. Y., died recently at the age of sixty-five years.

H. SEYMOR STEWART, M.D.

Dr. H. Seymor Stewart, of Elyria, Ohio, who was graduated at Jefferson Medical College in 1887, died at Thomasville, Ga., Feb. 8, 1888, of consumption of the lungs. His illness lasted but a few months.

F. H. TERRILL, M.D.

Dr. F. H. Terrill died in San Francisco on January 28, 1888. He was attacked by small-pox, which has been epidemic in that city, and died in forty-eight hours. His death has been attributed to his disbelief in the efficacy of vaccination.

JOHN L. MEARES, M.D.

Dr. J. L. Meares died in San Francisco, Cal., on January 15, 1888. He was born in Wilmington, N. C., in 1822, and studied medicine in the Jefferson Medical College, Philadelphia. He went to California in 1871, and was appointed Health Officer of San Francisco in 1876.

GEORGE A. CROSBY, M.D.

Dr. George A. Crosby, a very well known and highly esteemed physician of New Hampshire, died at Manchester, January 29, 1888, of congestion of the brain, after a short illness. Dr. Crosby was born in Lowell, Mass., in 1831, and was graduated at Dartmouth in 1852. He had been President of the New Hampshire Medical Society, and was a member of the Manchester Board of Health at the time of his death.

Official List of Changes in the Stations and Duties of Officers serving in the Medical Department, U. S. Army, from Feb. 12, 1888, to Feb. 18, 1888:

Capt. Wm. H. Arthur, Assistant Surgeon, leave of absence extended two months. S. O. 35, A. G. O., Feb. 13, 1888.

Changes in the Medical Corps of the Navy, during the week ending Feb. 18, 1888:

Assistant Surgeon F. W. Olcott, detached from the "Minnesota" and to the "Atlanta."

Surgeon T. C. Heyl, ordered to the Receiving Ship "St. Louis."

Surgeon H. M. Martin, detached from "St. Louis" and to the "Saratoga."

Assistant Surgeon Chas. F. Webster, ordered to the Receiving Ship "Vermont."

Assistant Surgeon James G. Field, detached from the "Vermont" and to the "Swatara."

Passed Assistant Surgeon Robert Whiting from the "Iroquois" and to the Coast Survey.

Assistant Surgeon Cloner C. Tracy, resigned, to take effect immediately.

Official List of Changes of Stations and Duties of Medical Officers of the U. S. Marine Hospital Service, for the two weeks ended Feb. 18, 1888:

Eugene Wasdin, Passed Assistant Surgeon, relieved from duty at Marine Hospital, Chicago; ordered to Marine Hospital, Mobile, Ala., February 16, 1888.

Seaton Norman, Assistant Surgeon, relieved from duty at Marine Hospital, New York, to assume charge of the Service at Evansville, Ind., February 6, 1888.

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Communications.

IS LARYNGECTOMY PREFERABLE TO TRACHEOTOMY?

BY WILLARD H. MORSE, M.D.,
WESTFIELD, NEW JERSEY.

It has been but a little more than twenty years since P. H. Watson inaugurated a new era in laryngology by excision of the larynx. It has been only fourteen years since Billroth first performed the operation for carcinoma of the larynx. And yet, since 1873 there have been no less than one hundred and thirteen laryngectomies performed. The operators have been such surgeons as Gussenbauer, Langenbeck, Thiersch, Heine, Caselli, Foulis, and others. And the results?

Hahn gives the statistics of fifty-two operations. Of these twenty-eight were successful in procuring from one day to seven months of life. This—as an interpretation of the term "successful"—is not particularly discouraging, but if we look at the results as shown from the blotted clinic-book of individual operators, we are not encouraged. Billroth, for instance, has in fourteen years done twenty-three laryngeal operations, of which five were total extirpations, seven partial extirpations, and eleven laryngeal sections. The five cases of total excision were all for carcinoma, and were all followed by death within from one day to seven months. Of the seven cases of partial extirpation, death occurred very soon in three instances. Of the ten cases of laryngo-fission, three were early fatal, and in six there was relapse or subsequent death. Of the twenty-two patients operated on, but one was really cured. Foulis's imperfect table of statistics includes twenty-six cases of total extirpation, of which all but nine suffered death or relapse. This issue is more favorable than Billroth has experienced, but not as favorable as Thiersch has, who had two recoveries out of four cases of total extirpation for carcinoma of the larynx.

From time to time we have had in the medical press more or less extensive accounts of these cases, and while too much cannot be predicated upon the results, there is much that is of interest concerning them.

Of Billroth's cases, perhaps the most important and interesting was one he operated upon in the summer of 1879. He removed from a woman at that time the pharynx, the cervical portion of the œsophagus, the larynx, a part of the trachea, and all of the thyroid gland, for a cancer of the pharynx involving the posterior portion of the larynx. He first did a prophylactic tracheotomy, and performed the major operation nine days later, after introducing the canula tampon of Trendelenburg. The incision was made along the anterior border of the sterno-cleido-mastoideus, and immediately upon opening the skin the operator found that the tumor was more extensive than he had supposed. Step by step he proceeded until the whole work was done. An artificial œsophagus was placed where the cervical portion had been removed, and aliment was introduced through it for four weeks, during which time the patient made a fair improvement, quite like recovery. At the end of that time this tube was removed, in the hope that the pharynx would unite with the lower portion of the œsophagus and form a true substitutive canal for the passage of food. After the removal of the tube, however, deglutition was accompanied by suffocation and vomiting, causing retraction, and necessitating the passage of bougies. In the sixth week a false passage was made in the peri-œsophageal tissue. After this, death from pericarditis soon ensued.

Langenbeck, who has operated three times, has a similar procedure. The following are the steps of his operation: First of all, tracheotomy is performed, and Trendelenburg's canula is introduced; then an incision is carried from the body of the lower jaw, midway between the angle and the symphysis, toward the greater cornu of the hyoid bone, and thence along the anterior border of the sterno-mastoid muscle as far as the upper extremity of the tracheotomy incision. Next, the submaxillary gland is removed, the lingual artery tied, and the hyoid muscles detached. The pharynx is then laid bare, and can then be dissected out, the larynx meanwhile being drawn up to the opposite side. There are two principal dangers in the operation; peri-œsophageal phlegmon, and pneumonia, from the introduction of foreign bodies into the air passages. Langenbeck is not on record as favoring an artificial œsophagus, but Kolaczek, who has had a successful case, had his patient nourished through such a tube for eight weeks. The removal of this tube is often followed by bad results. Langenbeck, and as well Koenig, of Göttingen, and Gussenbauer, of Prague, lost their patients when the tube was removed, pneumonia being set up by the passage of food into the lungs. To avoid this danger, Thiersch has proposed preliminary establishment of a gastric fistula.

The entire history of an interesting case, in which Dr. Foulis, of Glasgow, performed extirpation of the larynx, was withheld until the death of the patient. It appears that at the time of the operation, there was latent disease of the lungs; but the patient, a young man, survived for seventeen and one-half months afterwards—a longer period than in any similar case, so far as I know. During this time he enjoyed a useful and comfortable existence, working eleven months as a telegrapher, wearing the artificial larynx all of the time, day and night. Toward the end of the year, cough, hemoptysis, and night-sweats began to occur, and the interior of the trachea showed extensive ulceration, presumably tubercular. Death resulted from the pulmonary disease, and the operator has always expressed himself as positive that the extension of the malignant disease was arrested.

Dr. J. Solis-Cohen, of Philadelphia, has proposed, where the operation is practicable, a modified laryngectomy, by which the entire respiratory portion of the larynx can be removed, and the greater portion of the thyroid cartilages be left undisturbed to perform their function as shields. It is applicable to both the unilateral and the bilateral procedure; and not less than five distinct advantages are claimed for it. These are: (1) the rapidity with which it can be performed, with comparative safety to the patient; (2) the small size of the wound; (3) the preservation of the attachment of thyroid and hyoid ligaments and the several muscles; (4) the retention of the functional structures for deglutition; and (5) the leaving of a firm, natural support for the adjustment of artificial substitutes for the larynx. This modified method is so comparatively recent, and has been performed only upon the cadaver, that it is impracticable to pronounce on its full availability. It would seem from the past history of laryngology that laryngectomy is not yet a success or attended with any certainty of hope, all operations having given good results, but all patients suffering recurrence. Individual operators have done admirably, daringly and nobly, but the time that has elapsed since 1866 is not sufficient to have done more than suggest the possibilities of the operation. I can find, in 113 cases, only 29 in which the patient has survived six months, and yet only 62 (or perhaps 66), of the laryngectomies were for carcinoma of the larynx.

Since fully one-half of the cases of cancer of the larynx are unilateral, partial laryngectomy is in some favor, especially in England, where it is claimed that much better results are obtained from the operation than from that of total excision. This may well be, if cases are to be selected, partial laryngectomy having peculiar advantages in unilateral and intra-laryngeal epithelioma, and in recent, non-infiltrating sarcoma. It is obvious that where the cancerous implication is extensive it is useless. Perhaps if we were to have a "rule" in the matter, it would be best to do the entire removal. It promises as favorably, if not better than partial removal; but such promises are like those of the fortune-teller. There is no even chance of life, and if it be granted, it is a life of anxiety, dread and abject misery.

Beyond doubt, tracheotomy promises better results, and, moreover, fulfils all that it promises. It has been a means of saving patients by death from asphyxia so long that it needs no advocacy; but the indications for its performance in a wider field of usefulness may require a word of encouragement and a basis of establishment. There is virtually no other palliative treatment either in the first or second stage of cancer of the larynx. It relieves the patient from immediate danger to life; and when the morbid growth is so situated as to be beyond the

reach of intra-laryngeal treatment, there is no preferable method of procedure. It may, however, be stated as a cardinal law, that the operation is not to be performed unless there is immediate danger from suffocation or dysphagia. It is adopted as a preliminary measure of safety when thyrotomy is to be done, and results in the avoidance of suffocation, and the accession of greater certainty and safety.

In 1863, Czermak recommended infrathyroid laryngotomy; but it was not till two years later that Burow, of Kœnigsberg, carried it out. In this operation, as also in the combined method, a preliminary tracheotomy is performed.

Thus we may recognize that, after the abandonment of laryngoscopic treatment as impracticable for any reason, it is a surgical duty to employ tracheotomy as a means of arriving at mechanical or chemical treatment in preference to extirpation, either wholly or in part.

The following notes of two cases seem to me instructive as showing the power of tracheotomy in facilitating recovery and averting death.

A. D. C., a French sailor, 43 years old. Had had syphilis nine years before. Though the treatment of the secondary symptoms had been successful, he had suffered from throat symptoms, which had latterly become chronic. On coming under treatment, the pharynx was found to be extensively ulcerated, and the laryngeal and pharyngeal mucous membrane greatly thickened and sensitive. He was placed under constitutional treatment, but continued to fail. In the second week he coughed up several bits of necrosed cartilage. This led to a definite understanding of the emergency which soon arose. A succession of laryngeal spasms occurred, and in a third or fourth intermission I found suffocation so imminent that tracheotomy was performed. Subsequently the patient came under the care of his family physician, receiving constitutional treatment, and nothing more was heard of him till some ten weeks later, when he came to the city to have the tube removed. When this was done, there was no delay in the closing of the opening in the trachea. By arresting a fatal issue, time had been gained for efficient treatment, and the air being diverted from the diseased larynx, there was nothing to hinder cicatrization. It may be said that syphilitic ulceration and a carcinomatous or a papillary growth are entirely dissimilar. Admitting this, the former is quite as apt to occasion laryngeal stenosis as the latter, and it is, in a surgical sense, a more serious matter than carcinoma. Total extirpation for syphilitic ulceration would have been out of the question altogether, thus showing the value of the tracheotomy.

The second case was that of E. H., 35 years old, a taxidermist. He had had some little difficulty in deglutition for about a year, and had been hoarse and suffered from a slight cough for two or three months. There was no pain in the throat, and he applied for treatment of suppuration from the right middle ear. A laryngoscopic examination showed the epiglottis to be thickened, and a growth of the shape and size of a Lima bean projecting from the right side of the ventricular space. The vocal cords showed no indications of encroachment. Circumstances removed the case from observation until nine months later, when the laryngoscope showed the arytenoid cartilages infiltrated. (During this time the growth had been clipped.) He was advised to enter the hospital and have the operation of tracheotomy performed. This advice was heeded, and an ordinary tracheotomy canula was introduced. A dissection of a portion of the growth revealed the characteristics of epithelioma. At present writing (five weeks since the operation), the young man breathes easily through the tube, and there is great improvement in deglutition, cough and general health. It has since been learned that the surgeon who performed the clipping pronounced the growth papilloma. May not the intra-laryngeal operation turn a growth from papilloma to epithelioma, as suggested by Browne, of London? Further, may not this have been the case with the Crown Prince of Germany? Professor Virchow pronounced the growth a papilloma at the first, and Virchow is not an erring microscopist. It is now declared to be carcinoma. Did the operations performed on the Prince metamorphose it; and, if so, is that not another argument in favor of tracheotomy, with thyrotomy, if necessary, following?

The amelioration of the laryngeal condition which follows tracheotomy is striking, if the canula is inserted for syphilitic ulceration, carcinoma, papilloma, or for laryngeal phthisis, as Prof. Beverly Robinson recommends. Extirpation of the larynx is contraindicated, not only because of the ultimate almost uniform failure of that operation, but because the greatest amount of good to be obtained from it cannot equal the fortunate effect of prolongation of life from simple tracheotomy.

It may be a matter of interest at this moment, *apropos* of the two cases of leprosy now quarantined in a Philadelphia hospital, to take note digressively of the fact that the larynx of a leper is pathologically interesting and peculiar. The air-passages undergo changes, revealed to the laryngeal mirror as a thickened and congested epiglottis, a stenosis of the upper aperture, a tumefaction of the ary-epiglottic folds; the mucous membrane is dark red, the vocal bands of a dirty yellow color, and there are other changes, more or less persistent. Laryngeal disease occurs in nearly all cases of leprosy, provoking the husky voice of these unfortunates, which was noted as early as 1526, when Hans von Gersdorf, in his *Feldbuch der Wundarzenei*, remarked: "Das erst zeychen ist die heyssere in der stymm, und red, enge des stems." Elsberg, in 1879, thus described a leprous larynx as found on autopsy:

"The palato-glossal folds and the pharynx show a few nodules. The tip of the epiglottis is thickened to the extent of one-fourth inch. At base an abnormal yellow infiltration and superficial ulceration. Orifice of glottis presents an oval, puckered appearance. Mucous membrane covering vocal cords shows an almost uniform nodular thickening."

Shall laryngology ever know a time when the knife shall deal as willingly with laryngeal leprosy as it now deals with laryngeal syphilis and carcinoma?

PUERPERAL SEPTICÆMIA.

BY JAMES E. FREE, M.D.,
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The REPORTER for September 3, 1887, contains a *résumé* of the instructive discussion on puerperal fever, which took place at the recent meeting of the British Medical Association in Dublin. A careful reading of this paper shows that wide differences of opinion exist among English authorities as to its nature. The disease is not liable to change its character very much by reason of climate and location. At least it appears to me that its features as described by physicians across the ocean are the same as American observers notice.

Playfair is a vigorous champion of the septic theory. He makes a distinction between puerperal septicæmia and puerperal fever, the latter term he abhors, although maintaining that the puerperal disease is identical with surgical fever.

He says there are conditions due to chills, malarious influences, meterological states, etc., which present analogous phenomena, but are not related to the disease proper. His dictum is that puerperal septicæmia is the result of septic absorption through the genital tract, and it might be inferred from the language used that if a puerperal fever arises by the introduction of poison into the system through any other channel it is not to be called by the name common to the first.

The exact qualities of the material which has such an affinity for the generative organs of women are not stated, but since the effort is made to exclude so many possible sources of contammation it must have a multiple origin. The septic influences of the ordinary lying-in room are not similar to those which antisepsis is used to guard against when the accoucheur comes to his patient from the pathological laboratory. Whatever the cause may be, it is agreed that in conflict with bichloride of mercury solutions it is at once shorn of its strength to do evil. Therefore the partisan of this theory, like the Scribes and Pharisees, hold traditions in regard to the washing of pots and cups and many other such things. They say it is desirable at an early stage of labor to thoroughly syringe the vagina, and sponge the vulva with an antiseptic solution. And again when the head is distending the perineum the external genitals should be sponged with the solution. Why these rules are important is not entirely clear. If the atmosphere is so loaded with the germs of puerperal disease, absolute safety cannot be obtained short of an apparatus similar to that of a diver for both patient and obstetrician, and then have them immersed in a bath of bi-chloride of mercury solution.

Labor is not usually a rapid process, and the time that intervenes between the two bathings may be some hours. It can hardly be supposed that the first application thoroughly protects the genital organs until the second is in order. The contact of the antiseptic solution at best only continues for a few minutes, and if it does exert the specific action claimed for it, the genital tract will shortly be in a condition to absorb the septic material. If there is no danger to the patient except by means of the touch of the nurse and accoucheur, what use is this long prophylactic treatment? The cause of puerperal septicæmia, if it is carried into the vagina by the hand, must be something of the nature of the vaccine virus or syphilis. And if this disease is like surgical fever, we ought to meet with cases bearing a remote resemblance to it in the non-pregnant. The vari-

ous operations undertaken for the relief of diseased organs of reproduction, lead frequently to a rise of temperature and its accompanying features. If the same material was absorbed in this case that previously caused puerperal septicæmia, would the patient be in the same condition as her pregnant neighbor? The difference would be what pregnancy adds to the one.

Robert Barnes, of London, finds the cause of the disease in the patient. First, he sees a powerful influence at work to modify the constituents of the blood, in the shape of an acute process of growth; then, secondly, there is labor with its tension and strain of the nervous and muscular system; and, thirdly, the necessity for the large excretion of useless material. It is plain that whatever hinders nature's efforts to establish the normal relations of the parturient woman's organs and blood must aid in the establishment of puerperal fever.

In many labors absorption is improbable when the head is descending and stretching the perineum, because of the secretion which bathes the canal; and it is not plain why there is a necessity to soak the vulva in a mercurial solution when every blood vessel, muscular fibre and lymphatic structure is engorged to the limit of its capacity. No absorption is likely to take place when such obstruction to the circulation exists, and the rush of amniotic fluid, blood, etc., which accompanies the child into the world, would do as much toward getting rid of poisonous material as antiseptic douches. The hands of nurses and physicians should occasionally convey this septic material to the gravid woman's blood. Is surgical septicæmia possible from such a cause while the woman is carrying her child?

If a patient be confined in a house which is scientifically constructed, the mother ought not to require the rigid application of this system. Every obstetrician lays stress upon proper ventilation, sewer connections, etc., and some insist upon saturating the atmosphere with chemical agents capable of destroying the germs of disease.[1] The washing of the air is recommended by some; but what are the potent results to be obtained by these measures if the root of the evil is to be found on the hands and instruments which come into contact with the genital tract?

It is said that obstetricians may attend a case of labor immediately upon coming from the dissecting table, if they take the precaution to change their outer clothing and wash in the convenient mercurial solution. That washing is regarded as a preliminary step under such circumstances presupposes that the exhalations, and minute particles of decomposed cadaver, may be the cause of the disease. The hair of the individual who is engaged at the dissecting table will carry the odor of the dead, and why not the germs of puerperal septicæmia? But it is not insisted that he wash his hair with the mercurial solution; this is perhaps an oversight which the true disciples of the theory will correct, as soon as their attention is called to the fact. When a man absorbs the poison from a dead body into his system, it gives rise to a series of well recognized phenomena; and why should a woman infected with the same material be said to suffer with a disease which is equivalent to surgical fever? In the case mentioned in the discussion of the physician who infected sixteen patients with his forceps, after taking elaborate antiseptic precautions in other directions, there must have been criminal neglect in the care of his instruments; and it is wonderful that before this time others, besides his pregnant patients, have not been sent to the bourne from whence even antisepsis cannot bring tidings. The first patient upon whom he used the forceps after they became capable of transmitting puerperal septicæmia, would doubtless smear them with a conglomerate composed of the debris of the pregnancy, and if there was anything on the blades which warmth and moisture could revive, it might stay in the genital canal. How any physician could put a pair of forceps in their case without making some effort to clean them is inconceivable—it would be beastly. Let us suppose that he wiped off the blood stains and put the forceps in their place. The septic material in the vagina of his patient would find a convenient nidus in a blood-clot. Part of this clot might pass out at the ostium vaginæ, become desiccated, and perhaps even so finely divided by the attrition of the bedclothes, the patient's body, etc., as to be capable of diffusion into the atmosphere of the room. Such being the case, there would be nothing to hinder the passage of the septic material into the lungs.

Should this actually occur, would the blood be contaminated during the process of oxygenation, or would endosmose and exosmose be carried on in sweet oblivion of the germs of puerperal septicæmia? And if the blood in the lungs refused to take up the septic material, why should the blood in the genitalia, which is the same kind of blood, be so ready to do so? At the time the forceps

[1 This is a physical impossibility.—Editor of REPORTER.]

were used the woman is supposed to have been in good health, and necessarily some space of time would be required to elapse before its absorption and development in the blood of the victim. Culture experiments teach us that the process is not instantaneous, and if time is necessary, the physician and his forceps may be far enough away. Not to stretch the imagination too far, the same forceps which are accused of lighting the fire of puerperal septicæmia in one case, may have assisted at a delivery that ended happily. The second woman is perhaps said not to be susceptible to the poison. But the third gravid uterus into which they are thrust manifests symptoms similar to the first one. Now how has the poison been admitted to the third woman's blood? Its immersion in the secretions of the first woman's vagina, who manifested the disease later, could not have infected them a second time; because she was healthy at the time, and by the time she could have smeared them with the material to cause puerperal septicæmia, they were out of harms way. Therefore, if the disease was propagated by the specific germ of the disease on the forceps, it must have all depended through the whole series of sixteen, upon the supply on the forceps in the first place. If such were the case there ought to have been a descending scale of virulence noticed as the poison became scarce.

A forceps which would not be scoured by sixteen successive smearings with blood, mucous, amniotic fluid, etc., might perhaps be made harmless by washing in a mercurial solution. The poison introduced by the forceps might have come from a source peculiar to the environment of acccucheur and patient at the time of delivery. To say the least, the subject is somewhat obscure; but every physician ought to be fully persuaded in his own mind by a study of the subject in all its bearings before attempting to treat the disease.

The theory of Robert Barnes seems to me to offer the most satisfactory explanation of the phenomena witnessed. As he pointedly insists, season has much to do with the prevalence of puerperal fever, and because in the cold inclement months of the year it is more difficult to maintain an equable supply of pure air, it rages especially during that time. When houses can be thrown open and the summer air allowed to penetrate to every part, the unhealthy influences of dampness, sewer-gas, and all the ills which depend upon defective sanitation are much lessened in virulence, and the safety of the newly made mother more perfectly insured.

THE TREATMENT OF STERILITY DUE TO ATROPHIC UTERUS AND STENOSIS.

BY W. F. McTAGGART, M.D.,
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In connection with this subject, the following cases may present some features of interest:

A woman, aged 33, nullipara, married ten years, anemic, and much emaciated, consulted me for dyspepsia and leucorrhœa. The latter led to an examination of the uterus, which at once disclosed the cause of the failing health. It was a marked case of atrophic uterus and stenosis. The treatment instituted was rapid dilatation of the cervix and intrauterine faradisation, to nourish the organ by stimulation. The canal was kept patent by the use of sounds for three months. At this time the patient's health was greatly improved, and she was lost sight of for six months. She returned at the expiration of this period with premonitions of her former malady. Again electricity and dilatation were brought into requisition, the latter being made effective by the aid of four free incisions, postero-anterior and bilateral, which were carried well up to the os internum, one of them passing through. The cervix uteri was then packed with cotton saturated with solution of perchloride of iron, to check the hemorrhage, of which there was considerable. I kept the patient in bed two weeks, after which thorough dilatation was carried out at my office for five weeks longer. Two months from the date of the operation I dismissed the patient from my care with her health remarkably improved. Nearly a year after leaving me, she became pregnant; and now, eight years since I last saw her, in soliciting my interest in the health of a sister, she writes that her condition has remained unusually good, and that she is the mother of three fine children.

Another subject of atrophic uterus with stenosis, precluding pregnancy, was a married woman who gave birth to one child when she was only nineteen years old. Seven years afterwards she consulted me for uterine "trouble," having had no children during this interval. She gave a history of much pain endured for more than half these years, and was now suffering from nervousness. She had had the cervix dilated, and had been treated by many physicians, who gave as many different names to her malady. She was "tired of seeing doctors," but suffering induced her to make "just one more

effort to get relief." Examination proved the cervix to be greatly elongated, and so occluded as to suggest atresia due to laceration in childbirth, as evinced by the presence of bilateral cicatrices. The uterus was undeveloped, and there was considerable tenderness of the ovaries. This is an apparently contradictory condition, since congestion of the appendages usually leads to extension of the irritation, and increase, rather than diminution, of the volume of the womb. Electricity was employed, together with gradual dilatation, for a period of three months, with but little improvement. An operation, which had been proposed as the first requisite and deferred in deference to the patient's objections, was now performed for the elongation by passing a No. 8 sound, no larger being admitted, and cutting down toward it transversely, taking out a wedge-shaped piece anteriorly, and a corresponding one posteriorly, not reaching quite to the sound, taking care to leave an interspace sufficient to maintain union, and then bringing the wounds together with wire sutures. Subsequently incisions were made to complete the cure, and two children, and possibly more, were born to the patient afterward. A slight laceration, which readily healed, attended the birth of the first child. The second was born without any untoward results.

The next case which I will mention was that of an unmarried woman, 29 years old. She had suffered several years from dysmenorrhœa, shedding large shreds and clumps from the age of twenty-three to nearly twenty-eight years, when her menses ceased. She consulted me about one year later. Nervousness, emaciation, hysteria and a distaste for food characterized her condition. Examination revealed an almost shriveled state of the uterus, with occlusion of the os. Electricity, dilatation and incisions were employed, with the result of restoring her health to a considerable extent and re-establishing the menses. But five years of married life thereafter brought no issue.

Another case was that of a married woman 36 years old, from whom a uterine polypus had been removed some five or six years before. For more than three years she had suffered severely with pelvic pains, pains in the thighs, copious leucorrhœa and great nervous prostration.

The last nine months she could not leave her bed. Owing to her reduced condition, I desisted from operating until her strength was somewhat restored. This was accomplished by means of iron, strychnine, phosphorus and quinine, together with the induced current per vaginam. Nourishment: oatmeal, eggs, milk and oysters. Six weeks of this treatment fostered a condition to warrant me, as I thought, in operating by incisions and dilatation. Convulsions and some inflammation of the uterus followed the operation. An apparently critical condition existed for a few days, then a rapid recovery followed; she afterwards became pregnant, but aborted at nine weeks, and was apparently incapable of pregnancy thereafter, at least for five years, when I lost knowledge of her. After the abortion her menstruation was regular, and her health comparatively good.

Other cases of atrophy of the uterus which have responded satisfactorily to the above treatment might be recorded, but the instances here presented will serve my purpose, and are designed more to illustrate than to attest the value of the means here adopted as curative measures. Regarding the agents employed a few words touching the use of electricity may prove suggestive. Good results can be secured only by a prolonged use of the Faradic current; the galvanic being less efficient in atrophic structures. It must be persevered in for a few months at least, and perhaps repeated after the lapse of a month or two. The current should be as strong as the patient can well tolerate; the negative current being employed intra-uterine, or, if that is impracticable, to the os with the cup-shaped electrode; the positive over the abdomen and the lumbar space. Unfortunately each application should occupy from fifteen to twenty minutes; a fact obviously an obstacle to the busy physician, unless he have plenty of assistants.

As to the success attending dilatation with dismissal of the patient a few days after, as reported by some leading gynecologists, I have but rarely been able to attain it. Whether the cervix be incised or not, lacerated by divulsion or not, I have found a tedious use of sounds, in some instances extending over months, necessary to outrun the resultant congestion and render the passage patulous. Patients dismissed in from two to three weeks after this operation for stenosis have returned to me in such number, requiring a repetition of the treatment, that I cannot from my own experience—whatever that of others may be—advocate a summary disposal of such cases. My course is to thoroughly dilate, make incisions when necessary to aid, keep track of all structural changes; and, when normal with patent canal, dismiss my patient with a feeling of

security that the cervix is insured against future closure.

The consumption of time, the attendant expense of the service, and the irksomeness of the routine, all suffered by the patient, doubtless militate against the thorough carrying out or completion of the treatment. But as permanent results, and not temporary effects, urge our patients to judicious efforts, we can generally reconcile them to the tediousness of the procedure by instructing them as to its nature, and explicitly directing them to the object which is sought to be achieved.

Regarding the operation for elongated cervix, it has the merit of being conservative as well as exceedingly valuable. The section to be removed may be proportioned in area and depth to the elongation. But it is surprising what an amount of contraction is effected by merely snipping out a small piece on either side or around the cervix, and then allowing it to heal. By this operation, which I have for several years successfully adopted, not only is amputation of the cervix for elongation avoided, but better results are secured, inasmuch as the integrity of the os is protected, and in consequence of the coaptation and the result of the healing, the main object desired—that of shortening the neck—is accomplished.

HYSTERO-EPILEPSY SUCCESSFULLY TREATED WITH CHLORIDE OF GOLD AND SODIUM.

BY C. L. DODGE, M.D.,

KINGSTON, N. Y.

Case I.—Miss D., aged 17, pale complexion, slight figure, weighing only 90 pounds. When 7 years of age, she had chorea, which lasted for a year, but finally yielded to treatment. Menstruation came on at 13 years of age, and she always suffered greatly at these periods. The family history is quite remarkable; her father has had epilepsy for years, her mother had chorea when a child, and a brother has slight choreic twitchings of the left side of the face at the present time. When about 15 years of age, the patient had the first "nervous spell," as they termed it, which was brought on by anger at being refused permission to go to a ball. This attack, from what I could learn, was purely hysterical. After it, so-called fits occurred from time to time, increasing in severity and frequency, and assuming more and more the character of epilepsy. This state continued for two years, gradually growing worse, and all treatment up to the present time being futile. When I first saw her, she was having from two to ten fits a day, and one day she had forty. The paroxysms were very severe, often requiring two or three persons to hold her in the bed and to prevent her from injuring herself. There was sudden and complete loss of consciousness, pale face, eyes partially opened, pupils sluggish; she would bite her tongue and hands, and strive to bite her friends, would tear her hair out, and at the commencement would cry out with pain—at least she insisted that she had pain after her attacks were over. Her features were distorted and her convulsions, which were sometimes tonic, sometimes clonic, were more marked on one side than on the other. She manifested great muscular strength at these times, although she was very slight and delicate. She evinced no feeling, and firm pressure over the ovaries produced no effect; neither arresting the paroxysm nor giving rise to pain. These attacks lasted from three to ten minutes, with intervals of ten to twenty minutes. The number of paroxysms at any given time varied; sometimes she would have only four or five, and on one occasion she had as high as forty in one day. After having apparently exhausted her strength, she would fall into a heavy, half comatose sleep, followed by headache, dulness of intellect, and great irritability of temper. She had been treated with morphine hypodermically for a long time, which had the effect of relieving the spasmodic character of the attack and inducing sleep. Generally, on awakening she would appear rational and remain so for the rest of the day, but sometimes as the effect of the morphine wore off, she would have a return of the paroxyms. Chloroform would also control them; but for a short time only. Bromides seemed to have no effect whatever, which led me to think the disease was not epilepsy. Tonics of all kinds were tried; but they had no effect on her appetite or general health, nor on the nervous disorder. At last, I prescribed pills of chloride of gold and sodium, each containing $\frac{1}{20}$ grain. One was taken three times a day. The first box contained sixty pills, and before these were all used up she showed decided signs of improvement, her appetite returned, she gained flesh and strength, and returned to her work—that of a milliner—and seemed as well as ever. She continued the use of the medicine for several months and had no return of the malady. Nearly a year afterwards her mother told me she had had a slight attack, but it was so mild that she did not send for me. I directed

her to renew the prescription for the pills of chloride of gold and sodium, when she at once began to improve, and has had no return of the trouble. This is more than three years ago.

Case II.—Mrs. K., aged 28; dark complexion, short, stout figure; has one child 8 years of age, and has never been pregnant since; her menses are regular, but she always suffers great pain at these periods. Her menses appeared at thirteen years of age. At her first menstrual period she suffered greatly, and had fits for a whole day. She often has "fainting spells" at these periods. Her mother when young was subject to fits also. September 2, 1887, on the first day of menstruation she was seized with a fainting fit at the water-closet; everything grew dark, she said, and in trying to reach the house she fell and bruised herself somewhat. I saw her shortly after she fell, and found her unconscious, pale, cold, eyes closed, and pulse feeble. Several small doses of brandy and water were administered, followed by hot applications to the feet and legs, with inhalations of ammonia and the usual remedies employed in an attack of syncope. She rallied in a few minutes, when she complained of intense pain in her left side in the region of the ovary; pressure over the spot was painful, but had no other effect. I then gave her a full dose of morphine, and left directions to repeat it as often as necessary until the pain ceased. The morphine relieved the pain but affected her head unpleasantly, making her delirious. This all disappeared as soon as the effect of the drug passed off. She remained in bed for several days, after which she seemed as well as usual. Four weeks from this date, I was again summoned to find her in convulsions. Her menses had just appeared, and I was informed that before she became unconscious she had complained bitterly of pain in her left side extending up to her heart, which seemed to smother her. The convulsions were more tonic than clonic; the eyelids were closed, the eyeballs rolled upward, the pupils sluggish and somewhat dilated. Her mouth was closed, and respiration seemed to stop. Pressure over the ovarian region had no effect. She made no response when spoken to, and seemed not to hear or see. This attack lasted fifteen or twenty minutes, after which she recovered consciousness and complained of pain in her side. Mustard was applied to the side, and morphine administered for the pain. She now took to her bed and became somewhat hysterical, lost her appetite, complained of ugitive pains, and grew very irritable. She had these attacks frequently, sometimes two or three in a day. She was also troubled with nausea, perverted taste, and spasm of the throat. Usually just before a paroxysm, she said she felt a choking sensation in her throat, and a sense of impending suffocation. Borborygmi and tympanites were present, also a burning and itching of her face, with coldness of the hands and feet. At times there appeared to be a certain amount of swelling of the abdomen, and of the inner sides of the thighs. In the more severe attacks she would bite her tongue, and roll herself around the bed, so that she had to be restrained. After the attack she passed a large quantity of clear, colorless urine. At other times she imagined she was unable to empty her bladder. In addition to these symptoms she now complained of a continuous pain in the left side in the region of the ovary, with a slight amount of swelling. A uterine examination was made, but revealed nothing except a certain amount of tenderness and slight swelling. The temperature was never over half a degree above normal, and, notwithstanding the fact that she ate nothing, she apparently lost little flesh. She remained in this condition for eight weeks, absolutely refusing to get out of bed, saying she was too weak and suffered too much pain. Numerous remedies were tried with no apparent effect; bromides in large doses, morphia, chloral, valerianate of ammonia, quinia iron and strychnia, wine of coca, brandy, aromatic spirit of ammonia, viburnum, camphor, etc. Carbolic acid and calomel were given in small doses for the nausea, which at times was very annoying. Finally, after eight weeks of treatment with these remedies, I abandoned everything and gave her chloride of gold and sodium only, in one-twentieth grain doses three times a day, when to my surprise and gratification she began at once to improve, and in less than a week she got up, dressed herself, went to the table and ate with the family. She took this medicine for two weeks, and nothing else, and has remained free from convulsions from that time to the present.

These were certainly severe cases. That they were not epilepsy I think is perfectly clear. Neither can I consider them hysteria, pure and simple, as we ordinarily meet with it in this country. A recapitulation of the symptoms in both cases shows absolute loss of consciousness, insensibility of the pupils to light, biting of the tongue, followed by heavy half-comatose sleep, and on waking, headache and general soreness. This all resembles epilepsy; but it must also be added, that the face was always pale, globus hysteri-

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cus was present, and after the paroxysm passed the patient voided a large amount of pale, clear urine.

Prof. H. C. Wood says:[1] "As contrasted with the characteristics of the epileptiform convulsion, those of the hysterical convulsion are: the peculiar disturbances of consciousness, the presence of emotional disorders, and the tendency of the muscular contractions to simulate in an exaggerated form natural movements, and to become tetanic. Persistently clonic spasms pertain especially to the epileptiform convulsion, whilst tetanic rigidity is indicative of the hysteroidal."

Mills states[2] that two forms of hystero-epilepsy are recognized: 1. Hystero-epilepsy with separate crises, in which the symptoms of hysteria and epilepsy appear completely independent of each other, and in attacks perfectly distinct. 2. Hystero-epilepsy with combined crises, in which hysterical and epileptic symptoms are commingled in the same attack. In the first variety the same patient is the victim of two distinct diseases, hysteria and epilepsy. The second is hystero-epilepsy proper, and the term hystero-epilepsy should be confined to this form. Much confusion would thus be avoided. I believe, with Mills, that this disease is hysteria—not epilepsy. Hysteria major is the true term to apply, although in many respects the disease simulates epilepsy very closely, as pointed out above. The fact that the bromides have little or no effect is strongly against epilepsy.

I would also call attention to the temperature record in these two cases. At no time did the thermometer show a rise of more than half a degree above normal, which, according to Richer, is an important point in the diagnosis. It is stated by this observer, that an elevated temperature belongs to the epileptic state; while in hystero-epilepsy the temperature rarely rises above 100° F.

—The *Lancet*, Feb. 4, 1888, announces that Agostino Bertani, well known in recent history as surgeon-in-chief to Garibaldi, in the general's campaigns for the freedom and unity of Italy, has just been honored with a memorial tablet inserted in the façade of the Hotel Italie in Rome, where he died in the summer of 1886. Another of Italy's medical worthies receives similar recognition at Bologna, where, on the 2d inst., Dr. Magni, "the greatest Italian oculist since Vacca," had a commemorative tablet unveiled in his honor at the instance of his surviving colleagues.

[1] Nervous Diseases.

[2] *Amer. Jour. Med. Sciences*, October, 1881.

Society Reports.

MEDICAL SOCIETY OF NORTHAMPTON COUNTY, PENNSYLVANIA.

Report of committee on the

Rights and Duties and Powers of Coroners.

The committee appointed by the President of the Society to investigate the law in reference to the rights, duties and powers of coroners, respectfully reports as follows:

The question presented to them in the resolution is one to which it is difficult to give a definite and comprehensive answer. With the exception of two acts in reference to fees applying to Philadelphia only, there is no act of Assembly in Pennsylvania prescribing the rights, duties and powers of coroners. The office of coroner with the laws relating thereto was incorporated into the laws and customs of this commonwealth from the laws and customs of England, together with all those fundamental principles of our laws, which constitute what is known as the common law.

The duties of the coroner must, therefore, be learned from the common law, so far as in reference to this subject, it has been retained in the laws of this State.

The decisions of the courts, and, particularly those of the Supreme Court, being the only sources from which we may derive authoritative opinions respecting any disputed points of the common law, it is to these decisions that we must look for an answer to the question proposed in the resolution.

The reported decisions as to the duties of coroners are not numerous. Whether this meagreness of litigation on this subject in the court of last resort has been the result of a generally faithful performance of duties by coroners, who were not, therefore, called into courts to answer for any derelictions, or the result of public indifference to the acts of coroners, however, illegal these may often have been, your committee is not able to say.

In the case of Lancaster County *vs.* Dern, 2 Grant, 236, etc., the Supreme Court said: "There is no law that we are aware of, which defines all the subjects of inquiry for the coroner's inquest. It is true that the Statutes of 4 Ed. I., sec. 2, and 3 Herr. VII., (a portion of each of which statutes are in force with us), command the coroner to go to the place where anyone is slain, or has suddenly died, and inquire into the cause of death; but it has been observed that these statutes, being wholly directory, and in affirmance of the commom law, the coroner is thereby not

restrained from any branch of his power, nor excused from any part of his duty, not mentioned in them, and which was incident to his office before."

From an investigation of the cases reported your committee is of the opinion that the coroner not only may, but also should hold inquests:

1st. Where it is known that the deceased died from violence inflicted by another, or there is suspicion that the deceased died in such manner.

2d. Where the deceased committed suicide, or there is suspicion that he did so.

In cases of death comprised under these two heads it will hardly be disputed that the coroner ought to hold an inquest.

"It is the duty of the coroner to hold an inquest in all cases where there is cause to suspect a felonious killing of the deceased." Northampton County *vs.* Innes, 26 Penn. St., 156.

If such cases should be taken from his jurisdiction, his function would be entirely gone, and his office would become useless.

There are two more classes of cases in which it is not so easy to define the duties of the coroner. These are:

1st. Cases of sudden death, which, though it has been without violence, has proceeded from no known cause, and was not preceded by any known illness or ailment.

2d. Cases of death from the effects of an accident.

It is in these cases that doubt frequently arises, and objection is made to an inquest on the ground that it imposes costs on the county, and harasses the feelings of the relations and friends of the deceased, while at the same time it does not bring any corresponding advantages to the public.

Where the death is sudden, without violence, proceeding from no known cause and not preceded by any known illness, the coroner has jurisdiction, and may hold an inquest. These circumstances, of course, imply that there was no physician in attendance at all, or at such a late period, that he was not, up to the time of death, able from the symptoms to make a diagnosis of the case and explain the cause of death.

An exception would probably be made in the case of very old people, whose death there would be very good reason to believe was the result of senility.

If, however, the deceased was known to be ill or ailing previous to his death, especially if such illness was one of a serious character, and one from which death as a result would cause no surprise; and if the deceased at the time of his death was surrounded by members of his household, or by those who could not have held any but kindly feelings towards him in his extremity, and could not be suspected of having any motive to cause his death, and, particularly, if among these there was a physician who was treating him for his ailment, the case would be different.

It may be observed, however, that the mere presence and attendance of others, who may have come upon the scene when the deceased was *in articulo mortis* would not always be decisive. After-discovered circumstances might indicate suicide, poisoning, or some other unlawful cause of death.

If credible reports reached the coroner that, behind all indications of natural death in any particular case, there are suspicious circumstances, it would, of course, become his duty to investigate the matter at least by a preliminary investigation, and, if the suspicions should seem to be well founded, to hold an inquest. Suspicious circumstances, if reasonably well founded, would in any case of death, justify the coroner in holding an inquest.

It would undoubtedly be his duty to hold an inquest where the deceased is found, not in bed or in a residence or habitation, but in an out-house or building, or in a yard or field, or in the highway. If the deceased has been found in such places a suspicion might well arise that the deceased had died from unnatural causes.

In determining what his duty is in any particular case coming, or seeming to come, under this head, the coroner should carefully consider the circumstances of the case, and often also the character of the people who surrounded the deceased, or who were last in contact with him, and on whose conduct and character the holding of an inquest might cast an unpleasant imputation. He should try to obtain information not founded on vague and unreliable rumors; and, if such information brings the case within the principles above stated, he should proceed to hold an inquest.

In the case of Lancaster County *vs.* Mishler, 100 Penn. St., in which the right of the coroner to recover fees was disputed, it was decided that though the presumption is that the coroner has acted in good faith and on sufficient cause, yet in a suit against the county to recover his fees, this presumption is not conclusive, and that evidence is admissible to show that he acted in bad faith and knowingly, without sufficient cause or reason. In behalf of the county the offer

was made to prove "that at the time of his death the said Hahn (the deceased) was 78 years of age; that he had been sick, and attended by his regular physician for some days immediately preceding his death; that he died in his own house, surrounded by members of his family; that his death was a natural one, that there was nothing suspicious, sudden or extraordinary, and that all these facts were communicated to the coroner before he summoned his inquest." This offer was excluded by the court below, on the ground that the holding of an inquest is a judicial inquiry authorized by the laws of the State.

But the Supreme Court, as above stated, reversed this ruling, and held that the evidence should have been admitted. The Supreme Court said: "It is the duty of a coroner to hold an inquest *super visum corporis* where he has cause to suspect the deceased was feloniously destroyed, or where his death was caused by violence. Whenever he holds one the presumption is that he acted in good faith and on sufficient grounds. The question now presented is, whether in a suit by him for his services that presumption is conclusive against the county or may it be overthrown by evidence. The duty of a coroner to hold an inquest rests on sound reason, on that reason which is the life of the law. It is not a power to be exercised capriciously and arbitrarily against all reason. The object of an inquest is to seek information and obtain and secure evidence in case of death by violence or other undue means.

"If there be reasonable ground to suspect it was so caused, it becomes the duty of the coroner to act.

"If he has no grounds to suspect that the death was not a natural one, it is a perversion of the whole spirit of the law to compel the county to pay him for his services. Nay, more. If under the facts offered in evidence a coroner may hold an inquest, he may in his discretion, at the expense of the county, order a *post-mortem* examination, whereby those bound to the deceased by the nearest and most tender ties may have their feelings lacerated, in every case of natural death."

In case of death from accident, it is perhaps still more difficult to lay down a definite rule of conduct for the coroner. Such cases of death, being usually attended by horrible and extraordinary circumstances, are, no doubt, regarded by many as coming under the jurisdiction of the coroner, and it is probably true that in most of these cases coroners do proceed to hold an inquest. On the other hand, as the cause of death in cases of accident is often, if not generally, quite apparent, and as the reason for holding an inquest, if there is a reason, is often more or less obscure, it is to the holding of an inquest in these very cases that many object on the ground that it causes a needless expense, and harasses the feelings of the friends and relatives of the deceased.

In the case of Lancaster County *vs.* Dern, 2 Grant, 263, etc., the language of the Supreme Court is: "In this State the general understanding of his (the coroner's) duty is, that he is to inquire into the cause of all violent or extraordinary deaths."

From the language used in Crosby's case, 3 Pitts., 425, we may, perhaps, obtain a suggestion which will enable us to observe a distinction in cases of violent deaths from accident, and to determine with tolerable accuracy when the coroner has jurisdiction. In that case it is said: "An inquisition ought not to be held where the defendant (deceased?) came to his death by being caught in machinery which he himself was working, and no other person is suspected of contributing thereto."

It may be well at this point to state what is probably a fundamental principle in the law as to coroner's inquests, at least in cases other than those of suicide.

It is to determine, on grounds of public policy, whether any person has unlawfully contributed to the cause of death which has become the subject of inquiry, and has thereby made himself liable in a criminal or civil action.

An investigation by the coroner at the public expense, of cases of death, however extraordinary, from mere curiosity or for the purpose of advancing medical or surgical science will not be tolerated. The mere fact of death by accident, would not in every case give the coroner jurisdiction.

In Lancaster County *vs.* Dern, above referred to, the payment of the coroner's fees was resisted on the ground that the inquest was not necessary. The cause of death was the injury received in a collision of sleighs. The collision occurred on January 10, 1852, and the death on January 14.

The Court, after saying what has already been quoted from this case, proceeds as follows: "In this State the general understanding of his duty is, that he is to inquire into the cause of all violent or extraordinary deaths. It is frequently of great importance to the administration of justice, when the case becomes the subject of legal investigation, that death occurring by violence should be legally

inquired into by the coroner, and should he in a case of that kind neglect to do so, he would be justly censurable and might render himself obnoxious to the law for a neglect of duty. Now, in the case under consideration, the death of the person was not of an ordinary character, but one of violence, and, in our opinion, a case strictly within the supervision of the coroner; that it was his duty to ascertain, with as much precision as possible, the nature and cause of her death.

"It is contended that the death should not only be violent, but also sudden, and that both these circumstances must concur to give the coroner jurisdiction; that in as much as Catharine Lenocomer languished for several days after receiving the injury, therefore, although her death was violent, but not being sudden, the coroner had no legal right to hold the inquest. We cannot take this view of the law, for we are satisfied that, when the death occurs from any violence done to a person by another, although such violence may not terminate the life of the party suddenly, it is still the duty of the coroner to hold an inquest; for, otherwise some of the greatest benefit resulting from the office of coroner would be lost."

We conclude, therefore, that the coroner should hold an inquest in cases of death from accident where there were present others, or another, who, having participated in the work or operation from which accident occurred, may have contributed to that combination of circumstances which caused the accident, and as we have seen the death need not be sudden.

It is well known that such cases frequently become the subject of litigation in civil or criminal courts, and they are, therefore, proper subjects for investigation by the coroner. We should think that this is the feature which would give the coroner jurisdiction in almost all railroad accidents. We are all aware that most of these become the subject of litigation in a suit for damages.

If, however, it is clear that the cause of death was an accident, the causes of which were then and there set in motion, and that there was no one present who in any manner contributed thereto, it would be useless to hold an inquest, because in such a case there would be no probability that any one could be charged with having contributed to the casualty, and it would be of no interest to the public to have anything relating to such an accident officially determined.

There might, however, be exceptions to the rule just stated in reference to cases of accident where no one was present except the deceased. Such accident, though not directly contributed to by any one present, might have been caused by the previous neglect of some one in doing or omitting to do something, which neglect was the cause of accident. As where one leaves a hole or opening in the street or sidewalk uncovered which it was his duty to cover, and another should, without any contributory negligence, fall into such opening and receive injuries resulting in death.

Public interest or concern is certainly one important test which should determine the coroner's conduct. Where it appears that a life may have been sacrified by an act or an omission contrary to the duty which one owes to another, under the law, it becomes a matter of public concern and proper for investigation by the coroner.

In all cases of doubt there is one suggestion which it would be well for coroners, who mean to act according to the law, to heed; and that is, that they should carefully make a preliminary investigation of the most obvious facts, before proceeding to hold an official inquest.

W. B. Erdman, M.D., *Chairman.*
David Engelman, M.D.
J. Buzzard, M.D.

PHILADELPHIA COUNTY MEDICAL SOCIETY.

Stated Meeting, February 8, 1888.

The President, J. Solis-Cohen, M.D., in the chair.

Dr. Mordecai Price read a paper on a

Case of Nephrectomy for Gunshot Wound.

Maggie McG., of Avondale, Chester County, Pennsylvania, aged 14 years, white, pale, anæmic girl, was accidentally shot on Wednesday, December 21, 1887, at nine o'clock in the morning, while handling a four-barreled Sharp's pistol, 30 calibre. She had the muzzle of the pistol turned toward the right side, and while attempting to raise the lock with the thumb of her left hand, the trigger slipped from her hold and fired the cartridge, which entered her body at the junction of the ninth rib with its cartilage. The ball passed directly through the left lobe of the liver, entered the upper third of the kidney, and passing through, lodged in the deep muscles of the back near the spine. When I first saw her, twenty-four hours after the accident, her condition was an exceedingly alarming one; pulse 150, temperature 103°. She had passed, soon after the accident, a large quantity of blood from the

bladder; but at the time of seeing her she was not passing blood from the bladder, showing that, if there was still hemorrhage, it was into the peritoneal cavity, and also that the bladder was not wounded, for the urine was normal.

Symptoms of peritonitis were well marked; abdomen considerably distended. We had no difficulty in coming to a conclusion as to what was best to be done. Dr. Charles Penrose and myself at once advised the removal of the kidney. This was concurred in by Dr. Hudders and Dr. Ewing, the attending physicians. The patient was etherized and opened. A large quantity of clotted blood was removed from the abdomen, the wound of the liver was examined, both entrance and exit. No hemorrhage was found coming from it. The abdominal incision was then enlarged, and the blood removed from the region of the right kidney, when it was plainly seen that the hemorrhage was from that organ. The kidney was examined and found to have a hole in its upper third, large enough for a finger to enter. I then made a button-hole opening through the peritoneum with scissors, introduced the finger and enlarged the opening by tearing, and without much difficulty enucleated the kidney from its bed. The ascending colon was pushed back or inward toward the spine, and the opening in the peritoneum, through which the kidney was removed, was made in such a manner that the vessels of the bowel were not disturbed. The ligaturing of the pedicle was exceedingly difficult, Dr. Penrose having to tie the ligature the full length of his hand in the peritoneal cavity. Two ligatures were applied, one through the pedicle, tying it in halves, the other a large, heavy ligature with one knot; then the kidney was cut away and the ligature tightened before making the second knot. The stump of the pedicle or button, as it is called, to keep the ligature from slipping, had a portion of kidney structure in it. There was complete irrigation. A glass drainage-tube was left in the kidney wound and the abdomen closed. The patient rallied nicely from the ether, and on the morning of the second day Epsom salt was given in large and repeated doses, but could not be retained. On the morning of the third day a second attempt was made to have her bowels moved. Rochelle salt was used, and was followed by two or three evacuations and the passage of flatus by the bowels, which gave great relief. Patient did uninterruptedly well, with temperature not over 102°, up to the time (eighth day) of the removal of the glass drainage-tube, when rubber drainage was substituted, and was left too long, producing quite a rise of temperature and fetid pus at the bottom of the tube, which was at once relieved by the attending physicians removing tube and cleaning drainage track.

On January 4, I was telegraphed for, patient's temperature having been up to 103° the previous night. Abscess was suspected, either in the liver or muscles of the back. I met Dr. Hudders and Dr. Ewing, her attending physicians, in consultation, and found no positive indication of abscess; the girl being in a moderately good condition at the time, with a slight tendency to diarrhœa; temperature 100.4°, pulse 100. She continued to do well until the 11th of January, when Dr. Ewing wrote me: "Some new trouble seems to be developing in our patient; her temperature is 103.2°; her liver is enlarged and tender; complains of pains in left side and shoulder." On the 12th, there was quite a gush of pus and bile from the drainage-tube opening—about two ounces. This at once relieved her of high temperature and quick pulse. She has had many changes in the last three weeks, with slight discharge of bile and pus from the drainage-tube; but has constantly, but very slowly, improved. Her physicians have given her every attention, and to them I am greatly indebted for the care they have given her; nothing but their interest in the case could compensate them for their labors. For the result in this case I am greatly indebted to Dr. Charles Penrose, for assistance rendered during the operation. Length of incision, six inches. Kidney removed for hemorrhage.

In opening the discussion, Dr. Ewing, of West Grove, said: I have nothing to add, except that the condition of the patient is better than Dr. Price states. To-day there was only a drachm of pus discharged. There is refreshing sleep; temperature is normal in the morning, though there is a slight evening rise; appetite is good; the bowels are regular. I feel that recovery is assured. This child was on the verge of death when the operation was done—the pulse was 150; temperature, 103°; the extremities were cold; the body covered with clammy respiration. Improvement was manifest at once. I am personally much indebted to Drs. Price and Penrose for this operation, and I attribute its success to the neatness and dispatch with which everything was done, which exhibited a high order of skill.

Dr. J. B. Roberts said: The case speaks for itself. While I cannot speak from expe-

rience, it has occurred to me, and the same suggestion has been made by others, that the difficulty of tying the stump so far down and behind the peritoneum, might be lessened by getting the kidney enucleated and then twisting it so as to apply torsion to all the renal vessels, veins as well as arteries. Afterward the ligature might be applied with more ease; and this, whether abdominal or lumbar incision be made, though in the absence of experience I judge that it would be easier to do this with a lumbar incision. I presume that there was no intestinal wound in this case, no mention having been made of any.

In connection with the operation by lumbar incision, I might refer to an error of my own which illustrates the mistakes our lack of familiarity with operations in this region may lead us into. The operation was undertaken for a supposed stone in the kidney; but as no stone was found, it resolved itself into an exploratory incision and acupuncture of the kidney. The ordinary lumbar incision had been made with care, and I had come upon the kidney with ease. It was suggested that I should enlarge the wound upward and explore the upper end. A few muscular fibres stretched across the upper angle of the wound, and these I divided by a small cut, when a rush of air into the pleural cavity informed me that I had cut a small hole in the diaphragm. The accident did no harm; it was easily remedied with a few sutures; and the dyspnœa that persisted for a few days was attributed by the patient to the tightness of the abdominal bandage. I was not sufficiently familiar with operations in this region to realize to what extent the posterior attachment of the diaphragm to the vertebræ dips down here, especially when I saw, as I did, the main mass of the diaphragm bulging down as a great sheet in front of the point where I made the additional incision.

The PRESIDENT said: How does Dr. Price account for the bile?

DR. PRICE said: I cannot say where the bile comes from, unless it comes from the liver. The wound in the liver is about two inches from the gall-bladder. The ball took a diagonal course and came out at the margin of the liver, and then entered the kidney. I did not know what the effect of twisting the pedicle would be. I could bring the edge of the kidney within an inch of the wound. I consider the abdominal incision the proper one. In this case there were several considerations in its favor. Hemorrhage had already taken place into the peritoneal cavity; it gave us the chance to examine for wounds of the liver and intestines. We found only wounds of the liver and kidney. The liver was not bleeding, and we had only the kidney to deal with. In view of the discharge of pus from the liver, I now believe that it would have been better to insert into the track of the bullet in the liver a small glass drainage tube—this of Bantock's, which is of about the same diameter as the ball—and drained it. If, as has been stated to me by Dr. Wood, there has been no case of recovery from bullet-wound of the liver, we are not going to make the prognosis any worse by draining, and I think we might make it better.

DR. C. B. PENROSE presented a specimen of

Dermoid Cyst of the Ovary,

which he had removed two days ago. The woman also had a uterus filled with many subperitoneal and interstitial fibroids, and a large blood cyst of the other ovary.

DR. PENROSE also reported a case of

Obstruction of the Bowel by cancerous Mass; Operation; With Formation of artificial Anus.

The operation was performed seven days ago. There had been complete obstruction of the bowel for twenty-eight days prior to operation. Fecal vomiting occurred two days before operation. At time of operation there was immense abdominal distention, a temperature of 101°, and pulse of 150. An abdominal incision four inches in length was made, revealing complete occlusion of the descending colon by a cancerous mass twelve inches long, involving also the meso-colon.

Resection was made of the gut and meso-colon, and all indurated tissues were removed. The two ends of the divided gut were brought together laterally and united to each other, and the long axis of the abdominal incision, with continued suture, so as to make an artificial anus. A bucketful of fluid feces was discharged immediately after the operation. Relief was immediate; quiet sleep lasted for thirty-six hours. To-day the abdomen is flat; the pulse is 80 to 90; temperature, 99°; there is no pain; the tongue is clean; appetite good, and the patient doing remarkably well.

BALTIMORE CLINICAL SOCIETY.

Stated Meeting, Feb. 3, 1888.

DR. HIRAM WOODS read a paper on

Three Cases of Hallucinations due to the Administration of Sodium Salicylate.

The power of sodium salicylate to relieve the pain and shorten the duration of some of the intra-ocular inflammations is now, I think,

generally recognized. Iritis and choroiditis are the inflammations specially amenable to this treatment. Nor is its good action limited, as might be supposed, to those cases having a rheumatic origin. Iritis, clearly due to syphilis, without the least suspicion of rheumatism, I have frequently seen quickly relieved by the salicylates. Mercury will cure in time, of course; but the salicylates seem to have the power of aborting the attack. To accomplish this result, the system must be speedily brought under the influence of the drug, and this requires large doses. This fact gives us a clue to its mode of action. Large doses of the salicylates have the effect of weakening the heart's action, and reducing the blood pressure. These results are brought about by the combined depression of the contractile force of the cardiac muscle and of the vaso-motor centre. The latter produces not only a fall in blood-pressure, but prevents a rise in the pressure when the sensory nerves are irritated (Brunton, Materia Medica). These facts place sodium salicylate —if given in large doses—among the antiphlogistics, with aconite, veratrum, large doses of quinia, etc. Still, I can hardly believe that all the antiphlogistic effects of the salicylates are due to their depressant action on the circulation. Other drugs which lower blood-pressure—for instance, the bromides and those already mentioned—do not sensibly relieve the pain nor effect the course of iritis. There seems to be a selective action which we little understand. The large doses required often produce effects which are not only disagreeable, but may, in exceptional cases, become dangerous. Nausea, tinnitus aurium, deafness, fulness in the frontal region of the head, wakefulness, are the symptoms commonly met with. The amount which will produce these physiological effects usually stops the inflammation, or by its failure, induces us to use other means. More rarely, violent purging, involuntary evacuations, great dyspnœa and collapse are observed (Bartholow). Prof. Chisolm, of this city, reported two or three years ago a case of purging and involuntary evacuations occurring in a patient, who took, through a mistake of the druggist, 192 grain instead of 24. There were, in addition, marked de pression and weakness, but the patient fully recovered in two days. The force of the drug is sometimes expended wholly upon the nervous system. Such extreme effects as complete deafness, ptosis, strabismus are mentioned in our text-books as having been occasionally observed. Bartholow mentions a case of amaurosis due to the administration of 125 grains. There was no retinal lesion. Delirium and visual hallucinations are nervous phenomena more commonly observed than those just mentioned. Brunton says: "Salicylate of sodium in some persons tends to cause most disagreeable visions, whenever the eyes are shut, and I have seen it have this effect even in such a small dose as five grains" (Materia Medica). According to Bartholow, it is specially apt to produce delirium in drunkards. In the *British Medical Journal* of January 29, 1881, Dr. Bastian presents a series of five cases of delirium and visual hallucinations following the use of sodium salicylate in acute rheumatism. One case was that of an old toper, and the character of the delirium was similar to that of delirium tremens. In another the rheumatic poison seemed to be specially virulent, and the delirium was more like that sometimes observed in acute rheumatic fever, and due only to the rheumatic influence. Dr. Bastian concludes that if the patient's condition is such as to predispose to delirium, the salicylate will probably precipitate the attack, which, in its characteristics will resemble the delirium occurring in the predisposing disease. Cases, however, are here and there recorded in which, like those immediately to follow, there was no pyrexia to produce the trouble, nor any influence which could be held responsible except the salicylate.

Case I.—Mr. J. S., aged 43, occupation journalist, consulted me in April, 1886. He had had iritis in the right eye for four days. The iris was muddy, the pupil contracted, the periphery of the iris bulged forward, and there was pus in the anterior chamber. Pain was intense, not only in the eye, but in the temple. There was no syphilis, but an attack of rheumatism three months previous to his visit to my office, seemed to offer an explanation for his iritis. There was, so far as I could make out, no organic heart trouble. He gave a distinct history of phthisis in the family, and while I could not find a cavity in either lung when I examined him, there was dulness over the apices of both lungs, there was considerable emaciation, and he had a cough which was sometimes very troublesome. I have not seen him since I discharged him in the spring of 1886, after his iritis had gotten well; but he wrote me, from his home in Baltimore county, during the past winter that he had been obliged to give up nearly all his work, that his cough was incessant, and he was growing weaker. Undoubtedly he has fallen a victim to phthisis. His habits were temperate. He said he usually took a glass of sherry with his dinner,

and, sometimes, a little whiskey at bed time. I applied a compress bandage to his eye, ordered the instillation of a 4 gr. atropia solution, and prescribed for him 20 grs. salicylate of sodium every four hours. When he called at my office the next day, I was engaged, and he sat in the waiting-room about half an hour. After I had examined his eye, finding it greatly improved, he asked: "Doctor, is there a big colored woman with a child on her lap sitting on the sofa in the other room?" I told him I did not think there was, but to satisfy him, I looked and found no one there. On learning this, he said: "I wasn't *sure* of it. I didn't see her until I had been in the room a little while, and then she wasn't clear enough to make me sure." On questioning him, I found he had, to settle the question in his own mind, gone up to the sofa, and tried to touch the supposed woman, and found his hand came down upon the sofa. He then told me that he had taken four of the powders between 10 A.M., and 10 P.M., the day before, making 80 grains in all. He retired about 10 o'clock, and did not take a stimulant that night. After being in bed a little while he noticed his ears buzzing. He could not sleep, and soon thought he was having a dispute with his son. He sat up in bed, made up his mind that it was all imagination, laid down again, and talked away at his son as much as ever, so much so that his wife asked him to stop talking. After while the delirium changed and he thought he was at the telephone in his office, and couldn't speak above a whisper. He got out of bed two or three times during the night to answer a supposed telephone call. In the morning, while coming to town in the cars, he was troubled by seeing a black cat on his knee. He could convince himself that these things were all hallucinations; but no sooner would he do this than they would all come trooping back as real as ever. When standing alone he suffered from giddiness. His pulse was about 80, temperature normal. I had him pass his urine in my office and found it free from albumin. The salicylate was stopped. He slept very little that night, but the next day seemed completely himself. The iritis was afterwards treated with potassium iodide and the alkalis.

The other two cases occurred in the private practice of Prof. Chisolm, who has kindly written out for me the following notes:

Case II.—L. G., aged 50, of temperate habits, has been for ten years troubled with repeated attacks of specific iritis. Each attack runs its tedious course of six weeks or two months under the orthodox treatment of iodide of potash and mercury, with the local use of atropia and an occasional application of leeches to the temples. Four years since the treatment was changed to the salicylate of sodium in 25 grain doses given four times a day. The drug alleviates very promptly the inflammatory attacks, and enables him often to get out in a fortnight—a marked shortening of the paroxysm. In his case the remedy is not without its detractions. It does not disturb very materially his digestion, but when continued for some days produces very curious psychological effects. By the fourth day of taking, particles of dust become conspicuous against white surfaces and pollute the water which he drinks. The particles covering his white bed-spread grow in size into green flies and some of these develop into green frogs with a few green snakes. They are not stationary but are in constant motion. He knows them to be an illusion, but they look very real notwithstanding. If the medicine is stopped at this stage of the mental disturbance, in twenty-four hours they are all removed, disappearing in the transition forms in which they introduced themselves. Should it be needful to continue the large doses of the salicylate, figures of men, not always with the most pleasant countenances appear on the scene. At one of my morning visits, my patient reported his night's sleep as much disturbed by the intrusion of three men into his chamber. In waking, by the dim light of the turned down gas, he saw three men inspecting his box of valuable papers, which they for convenience had transfered to a side table. He reasoned with himself that no one could get into his house and that his body servant was in the contiguous room. He could shut out the vision by closing his eyes. At my visit he was sitting facing an open door leading into the next chamber. After describing his visions of the previous night, he said: "Now I know perfectly well that there is no one in that room, pointing to the door, and yet there stands in a threatening attitude a big man with an ugly club. I can shut him out by shutting my eyes, but there he is all the same."

On another occasion, after using the salicylate for some days, with the recurrence of motes, then flies, frogs and snakes, always green ones, I found him at midday sitting in the dining-room. As soon as I had examined his eyes and found that the injection had nearly disappeared, he said that he was very glad of it, and could now stop the sodium, because the hallucinations were becoming annoying. Just before I had

arrived, a mouse had come out from under the grate. After playing about on the rug, it commenced to puff up, and became a cat. The inflation continued, the animal becoming larger, until it assumed the appearance of a tiger, upon mischief bent. When the animal crouched with the intent of springing toward him, he asked his mother, who was reading the morning paper at the window, to come toward the fireplace. In doing so, she got between himself and the threatening animal, and the illusion vanished. During these conditions of mental excitement, the reasoning powers were never disturbed, nor did the conversation at any time indicate otherwise than a clear head. In this case the psychological influences seemed always to run in the same channel. These experiences had occurred to him on several occasions, at many months of interval, and always in a regular order. After three or four days taking large doses of the salicylate, he would mention to me: "Doctor, I saw the little pieces of stick in my basin this morning; the flies will come before the day is out."

Case III.—Miss S., aged 50, had been operated upon for double acute glaucoma. Vision had been reduced to light-perception before operation, and was so perfectly restored that she could use her eyes for hours daily in confined literary pursuits. Four years after the iridectomy, her left eye was attacked with a sharp inflammatory attack, which she conceived to be a return of her glaucomatous trouble. I saw her after three days of suffering, and found an acute attack of iritis, with some pus in the anterior chamber, a heavy rim of injection around the cornea, a very painful eye, with very dull vision. The salicylate of sodium was given in twenty-five grain doses, four times a day. By the second morning all congestion had disappeared from the eye. The media had cleared up in a wonderful manner, and vision had returned. She stated that she had had a most horrible night of hallucinations of most disagreeable forms. She was very glad to know and feel that the eye was so very much better. She had made up her mind, from the horrors of the preceding night, that she could not take another dose of the medicine, even if the safety of her eye depended upon it.

In my own case and the last of Prof. Chisolm's, the delirium came on during the first ten hours of the administration of the drug. In the *Practitioner* for May, 1882, Dr. C. S. Coulston publishes an interesting and exhaustive thesis on the use of the salicylates in rheumatism. Speaking of this delirium, he says that it usually comes on within the first eight hours, and is due to overwhelming the nervous system with large doses before tolerance is established, which can be readily done. If tinnitus aurium appears, the salicylate, Dr. Coulston thinks, should be discontinued until the tinnitus has gone. Then the salicylate can be given with freedom. Each of the five cases reported in the *British Medical Journal* by Dr. Bastian, afterwards took the medicine without trouble. In the extremely interesting case (the first narrated by Prof. Chisolm) the medicine seems to be well borne for three days, and then the delirium comes. Tolerance is not established. This case also opposes the remark of Brunton's that the hallucinations only appear when the eyes are closed. In each of these cases there was full knowledge that the objects seen *were hallucinations*, but they could not be permanently driven away. The patients were, on this account, not greatly terrified. Dr. Coulston states that the hallucinations are usually of a harmless, non-terrifying character. One of his patients insisted that a bundle of rags in the corner was the baby of an intimate friend, and that he had to take care of it. Occasionally, however, the delirium takes the form of mania, and the patient is violent.

In those diseases which sometimes of themselves cause delirium, the question of diagnosis becomes an interesting one. Dr. Coulston shows that the salicylic delirium is to be distinguished from that due to the rheumatic influence by the absence of fever and lessening of the joint pains at the time the delirium occurs. This was so with his cases, and with those reported by Dr. Bastian. The latter gentleman quotes the observation of Simon that delirium in rheumatism means involvement of the heart, and this may throw doubt on the influence of the salicylate in causing the hallucinations. In three of Dr. Bastian's cases there was no heart complication at all. From the delirium of drunkards (*delirium tremens*), it is to be diagnosticated by "the absence of tremulousness in the hand or tongue."

The manner of the production of the delirium is also an interesting question. As some of the cases also showed albuminuria, it was supposed that acute nephritis had resulted from the use of the salicylate, and that uræmia had caused the delirium. Subsequent cases have disproved this. In only one of Dr. Bastian's cases was there albuminuria. Dr. Ackland, quoted by Coulston, "thinks that uræmia, due to the great dimi-

nution of the amount of urea excreted by patients taking salicylates, may be an important factor in the production of the delirium. Dr. Bastian's opinion—that it precipitates an attack of delirium impending from some other disease—has already been alluded to. By others the delirium has been supposed to be due to impurities in the salicylate, and it is asserted that the *pure* salicylate never produces delirium." Dr. Coulston concludes his study of this branch of his subject with the remark: "The direct action of the salicylates on the nervous system is sufficient to account for the delirium, apart from either albuminuria, uræmia, or a rheumatic complication, though * * * * these would be predisposing causes."

Foreign Correspondence.

LETTER FROM VIENNA.

The feature of work in this city so attractive to the American student, is its purely clinical character and the large field for practical work and manipulation under teachers renowned for their scholarly methods.

Increased facilities have more than offset the restrictions placed upon the management of the General Hospital by the Government, in favor of the Austrian and Hungarian students. In many popular courses a certain number of places are reserved for the native students, and the same applies to all of the summer courses.

The clinic of Prof. Nothnagel, formerly of Jena, is very popular with Austrian and Hungarian students, and hence it is difficult to obtain satisfactory places in his amphitheatre. He is a thorough scholar, conservative to a safe degree, an admirable lecturer and an esteemed teacher; and his course of clinical demonstrations on diseases of the chest is very complete. The great prevalence and variety of tuberculosis in this city furnishes an abundance of clinical material, and permits systematic demonstrations in all stages and forms of this disease. Nothnagel depends upon the presence of the bacillus tuberculosis in the sputum in making his diagnosis. At a recent lecture he emphasized this point, and urged the necessity of familiarity with methods of staining, and systematic search for the bacillus in the sputum of all cases of so-called catarrh of the apex. At the same time he acknowledged that in the incipient stages one may be baffled in the search, but generally, he says, because of imperfect methods; since he believes that the bacillus tuberculosis is present in the products of disintegration of all tubercular formations. His imitations and illustrations of the normal and pathological sounds elicited by physical diagnosis are very accurate and graphic, and his methods in general demonstrate that the progress of internal medicine is not entirely in the attractive fields of pathology opened up by modern study of bacteriology and chemistry.

His treatment of croupous pneumonia is decidedly expectant. He resorts to antipyretics only exceptionally, and in many cases in all stages before the class, I have not seen the use of any chest applications whatever. He recently considered a rare form of anæmia, occuring in Egypt, where tape-worm is very prevalent and its effects are very pronounced. In addition to the usual expression of malnutrition, bowel hemorrhages occur, and the patient is brought very low. Prof. Nothnagel inclines to the theory that some chemical product of the worm has a direct depressing effect on the hæmato-poietic system, thus producing extreme anæmia. The danger in such cases lies in the risk of administering efficient doses of the tæniafugé, and yet the anæmia obstinately resists treatment until the cause has been removed.

Prof. Schrötter, or rather his assistant, Docent Karis, has had two operations of tracheotomy for obstruction of the trachea before the class. The first was one of traumatic hemorrhage, and the patient was with much difficulty resuscitated from the combined effect of the hemorrhage and asphyxia. The second operation was for the removal of large polypoid growths below the vocal cords in a little girl. Both cases are doing well. Professor Schrötter exhibited a case illustrating the beneficial effect of tracheotomy in laryngeal, and even pulmonary tuberculosis. The patient was a woman, over 30 years old, who, before the operation, had distinct evidences of the involvement of the larynx, with cavities in the apex of the lung. She began to improve after tracheotomy, and gained thirty or forty pounds in weight, with apparent cessation of the tubercular manifestations, after a lapse of now eighteen months.

Privat-docent Chiari recently exhibited a case of leprosy of the larynx from the wards of Prof. Kaposi. The man is a Greek, and has been here for some time, enjoying apparently unrestrained freedom of the hospital precincts.

Prof. Störk is rather under a cloud in professional circles, after his deliberate attack on Sir Morell Mackenzie, and doubtless he himself feels the reaction the more forcibly

since the recent favorable turn of affairs in the case of the Crown Prince of Germany. A most amusing dispatch was recently published in the leading Vienna paper. It was to the effect that Professor Virchow had reversed his decision as to the nature of the Crown Prince's disease, on the ground that what he had taken for soft cancer cells was merely the deposit of small particles from a dish of preserved fruit, just eaten by his Highness.

Professor Joseph Gruber conducts most satisfactory ear clinics. He has great confidence in operative measures in general, and is very skilful in manipulations. The use of the catheter is almost the rule in middle-ear inflation, and bougies are very frequently used in Eustachian tube disease. He treats inveterate tinnitus aurium by incisions of the drum membrane, releasing the long process of the malleus, and altering the tension in the internal ear. He has tried injections of hydrate of chloral, but with indifferent result. A new collodion-like substance, used in photography, offers an excellent medium for closing old perforations. It is called photoxyline, and is applied direct, with but slight pain, with a camel's hair brush.

There has been a series of unfortunate results in cases of mastoid disease in the wards of Prof. Politzer. None of them admitted of operation. The autopsy of one, a young girl, revealed an abscess, which had burrowed down along the course of the sterno-mastoid muscle into the anterior mediastinal space.

The death of Dr. Craig, of Middletown, Conn., in December last, made a deep impression on all of his colleagues. He had suffered from middle ear disease for some time, and it culminated in involvement of the venous sinuses, with a fatal result in a short time. Dr. Craig was graduated from the Harvard Medical School in 1883, and came abroad in November, 1887, to pursue his studies. His thorough education was acquired by his own energy and ambition, and was most creditable to him. His disease was most intractable and baffled the skill of the best specialists in Europe.

Prof. E. Fuchs, successor to Prof. Arlt, is carrying on a most successful clinic. The size of the ambulatorium (number of walking patients) is an indication of the popularity of the clinic, and there are between one hundred and one hundred and twenty-five receiving treatment daily. In his cataract operations the modified linear incision is used exclusively; and in ordinary cases the capsular forceps are substituted for the kooh in removal of the capsule. A few weeks ago Prof. Fuchs extracted a small piece of iron from the vitreous chamber with remarkable success. The patient was a young boy, and nearly a week had elapsed since the accident before the operation was undertaken. Several distinguished visitors were in attendance, and among them Karl Theodor, brother of the Empress, who has interested himself not a little in eye surgery. The foreign body lay not far from the posterior wall of the eye. An incision of sufficient size to admit the pole of the electro-magnet was made in the sclerotic, and on the second introduction the piece of iron was found clinging to the magnet. The case went on to a most favorable recovery. Prof. Fuchs is a clever operator, and very successful in his general management of the wards. His antiseptic precautions are extreme. All instruments used in operations on the eye are first heated in boiling water for some time. During the operation corrosive sublimate solution (1 to 5000) is used, and the after dressing is begun with pulverized iodoform and gauze.

Prof. L. Mauthner recently announced before his class the discovery of a new local anæsthetic by Lewin, of Berlin. This alkaloid, erythrophlœine, can only be used in very weak solutions; one to one thousand has been found quite efficient. The anæsthesia may last one to two days, or more. There is but slight or no effect on the pupil except in strong solution, and then it is a myotic. Its penetrating power is much greater than that of cocaine, and it will doubtless be useful even in enucleations of the eye, and in other fields in which cocaine has failed. It is a heart depressant in strong solutions, but there is no constitutional effect produced by the weaker solution. The anæsthesia comes on somewhat slower than that of cocaine. It was a remarkable coincidence that even during these remarks, Dr. Koller, the student who announced to the world the remarkable properties of cocaine, entered the room and was presented by the professor. Dr. Koller is still carrying on his studies here as assistant in different departments, preparatory, I have heard, to coming to America.

The Hygienic Congress of September, was a decided success. Vienna is indeed most hospitable, and all joined the local medical body in entertaining the unprecedented assembly of representative scientists. It can scarcely be said that they have reformed Vienna in her many unhygienic features, but all civilized lands must soon feel the influence, to a greater or less degree, of the published proceedings and individual studies

of this assembly of scientists. It was curious, however, to hear hygienists discussing questions relative to the welfare of all people, in an atmosphere loaded with carbonic acid.

The larger part of the nearly three thousand members in attendance came from Austria and Hungary, but France, Germany, Russia and the Scandinavian countries, sent large representations. England was represented by a very distinguished body, including Sir Spencer Wells, Francis Galton, Prof. Frankland, and others equally famous for their labors in sanitary science. The part taken in the discussion by the English delegates was very important, and they succeeded in having London chosen as the place of next meeting, for 1891.

Prof. Pettenkoffer remarked in his opening address, that the study of hygiene, as a science, is growing beyond the comprehension of the medical profession, and unless medical instruction is modified to include more of this instruction, it will soon stand entirely free from their fostering care, as an independent science. Our own country is behind the other great countries in labors in this field, and only by systematic energy can a better position be gained.

THOS. HUBBARD, M.D.

February 3, 1888.

PERISCOPE.

The Diagnosis and operative Treatment of Intestinal Obstruction.

Mr. Henry E. Clark, in a paper read before the Glasgow Medical Society, and published in the *Glasgow Medical Journal*, January, 1888, discusses the always interesting subject of intestinal obstruction. At the outset of his paper, he alluded to the difficulties surrounding the study of this subject, but looked hopefully for progress in the near future, both as regards diagnosis and treatment, in consequence of cases of intestinal obstruction now coming under the hands of the surgeon instead of the physician. While deprecating hurried and inconsiderate resort to operation, he showed that, for a large number of cases, this gave the only chance of recovery; and pointed out that, even when unsuccessful, abdominal section gave valuable information, which, if accumulated, would give a sounder basis to our knowledge, and lead to the saving of many lives. He next passed in rapid review the several forms of intestinal obstruction, and stated what he believed to be the essential diagnostic points; he illustrated his remarks by short histories of some of the cases which had passed through his hands during the past few years.

In summing up his operations, he laid down the following propositions:

1. Much evil is done in cases of intestinal obstruction by the injudicious use of purgatives. By their use the incomplete obstruction becomes complete, and the chronic obstruction becomes acute.

2. The most important question to decide is whether the obstruction is complete or incomplete. If flatus is passed *per anum* the obstruction is incomplete, and we are justified in waiting on in hope, and doing our best to avoid operation.

3. Opium is still our mainstay, and should be carefully and persistently used. Next to opium, nothing is so valuable as belladonna, both administered by the mouth, and applied externally to the abdominal wall. The diet should consist of milk, alone, or mixed with soda water or lime water.

4. The treatment by shaking the patient, as recommended in Erichsen's *Surgery*, last edition, being simple and safe, might be tried, and no doubt in some few cases would be found successful.

5. If opium, belladonna, enemata, and shaking are found to give no permanent relief —the obstruction being complete or becoming more complete, pain increasing, pulse not improving, abdominal distension getting greater, peristalsis visible, vomiting a marked feature—counsel operation. Undoubtedly in such cases abdominal section by mesial incision offers the best chance of relief.

6. Diagnosis of the exact site of the obstruction is generally difficult. Early vomiting generally means that the obstruction is high up. Much may be learned by careful percussion of the abdomen, especially along the line of the colon.

7. In cancer of the bowel, where there are signs of obstruction in the upper part of the pelvis, we should give our patients relief from the immediate symptoms and an extension of life by colotomy.

8. In the earliest condition of intussusception, inflation, by means of bellows or special force pump, offers a chance which should not be neglected; but in a latter stage it is accompanied by risks, both real and great, so as to render its use inadmissible.

Perforation of an Eye-ball with the Knot of a Whip.

A remarkable, if not unique, accident occurred in London recently to one of the staff, at the Paris Hippodrome. Whilst some ponies were being put through their usual training, an attendant, who was standing just outside the ring, suddenly felt a severe

blow upon his left eye, which, at the time, he believed to be due to a small stone. The next day the patient, on the advice of Dr. Towers Smith, the medical officer of the company, was removed to the West London Hospital, and, on the following afternoon, symptoms of panophthalmitis having commenced; enucleation was performed by Mr. H. Percy Dunn, assistant ophthalmic surgeon. On examination of the globe after removal, a large knot from the lash of the whip which had been used in the ring was found lying imbedded in the vitreous, the knot having passed into the eye through a jagged perforation at the corneo-scleral junction just below the horizontal meridian on the inner side. The interest of the case rests in the fact that, from accurate measurements which have since been made of the whip, the lash, and the *locale*, the man must have been distant from the end of the lash at least six feet when the whip was cracked; and the only explanation of the occurrence, which seem to be possible, is, that the knot was suddenly detached from the lash, and, with the momentum it had acquired from the cracking of the whip, penetrated the tunics of the globe, and caused the loss of the eye. —*Med. Press and Circular*, Dec. 14, 1887.

Examination of Sea-Air for Bacteria.

In the *Zeitschrift für Hygiene*, I. S., 421, Fischer has a paper upon the results of his examination of sea-air for bacteria in a trip which he made to the West Indies. In these examinations he used Hesse's method. He found that while the quantity of germs was considerable near the land, it was slight at a greater distance from the land (over ninety miles). But if the wind was from the sea, the air was free from germs at even a short distance from the land, showing that the direction of the wind has more to do with the quantity of germs in sea-air than simple distance from the shore. With reference to the statement that exceptionally at a very great distance from land (according to Darwin, about 1000 miles from the continent), a rain of dust may occur, the experiences of Fischer possess validity only for ordinary conditions. As regards the kind of micro-organisms found in the air, the moulds preponderate in comparison with the yeast fungi and the bacteria.

Finally, he investigated the sea-air by means of nutritive gelatine spread upon exposed plates. In these experiments contamination of the plates often occurred through scattering of the sea-water. In those which escaped this, subsequent test-tube investigation established the fact that the sea-air at a certain distance from the land is free from germs.—*Centralblatt f. d. Med. Wissensch.*, November 5, 1887.

Circulation of Blood in the Brain.

This subject has been studied anew by Wagner and Gaertner (*Wiener med. Blätter.*, 1887, No. 16) by exposing and opening the posterior facial vein, and measuring the amount of blood escaping in a given space of time. Among other problems, the influence of certain drugs was studied. It was found that morphia had little influence on the rapidity of the flow. Chloroform caused an enormous increase of the flow, as much as five times the original rapidity, although in a late stage of the narcosis the blood-pressure fell notably. With the disappearance of narcosis, the rapidity decreased. Amyl nitrite had a similar, though less intense, effect. Irritation of peripheral sensory nerves caused hyperæmia, never anæmia. —*Centralblatt für Chirurgie*, Nov. 12, 1887.

Local and intestinal Antisepsis in the Treatment of Furuncles.

P. LeGendre reports to *Le Concours Médical*, January 28, 1888, that he has tried the method of treatment, which has recently been recommended by Prof. Bouchard. A patient applied to him for treatment for a very large boil on his neck, the core of which had begun to be discharged. In the neighborhood of this boil another began to point, but it was still hard. The patient was much alarmed, because, two years before, he had suffered from an eruption of more than fifty boils, which for three months had embittered his existence. LeGendre protected the affected parts with an antiseptic plaster, which was to be changed twice a day, and directed the patient at these times to bathe the surface with a hot solution of corrosive sublimate, one part in one thousand. As there were undoubted signs of digestive derangement, he ordered, in addition, the following prescription as an intestinal antiseptic:

> Beta naphthol,
> Salicylate of bismuth,
> Carbonate of magnesia, of each, 4½ grs.
> M.—To make one powder.

This powder was to be taken every fourth hour. In eight hours the patient returned in excellent spirits; the first furuncle had dried up, the second was aborted, and there was no sign of the appearance of any others. The treatment was kept up with strictness for a week, and then stopped.

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adulterated wares might be detected, either by the regular operation of the work of analysis or by a special analysis demanded by a suspicious customer, would probably restrain very materially those whose consciences would not prevent them from practicing dangerous adulterations of articles of food and drink.

For the securing and carrying out of a law such as we have indicated, none ought to be more ready than the large and worthy class which holds that lard is better and cheaper if made with cotton-seed oil, or that which thinks that oleomargarine is preferable to butter. Those who think that water or chalk improves milk, or that lead chromate is a good thing to put in cakes, or that poisonous coloring matters do no harm to candy, will hardly favor the appointment of public analysts. There is a homely old saw which says:

> "Rogue never felt the halter draw
> With good opinion of the law."

But we believe that all who respect honesty and fair dealing, will agree that public analysts, with large discretionary powers, ought to be a part of the sanitary machinery of every civilized land.

LOCAL REFRIGERATION WITH CHLORIDE OF METHYL—STYPAGE.

The use of various agents for the production of cold as a local condition for the purpose of lessening pain or annulling sensibility is no new thing. No doubt the human race was in its infancy when it was first discovered that cold water exercised a soothing influence upon many painful states. But the last forty years has witnessed a development of this knowledge, until the use of cold water as a local anodyne, or anæsthetic, is one of the recognized procedures of medical and surgical therapeusis. From cold water physicians have proceeded to the use of ice, of ice and salt; then to that of evaporating ether, after ether was discovered; and, after the invention of the atomizer, a variety of substances have been used to abstract heat by their rapid passage from a liquid to a gaseous state. For some time the chloride of methyl has been regarded as the most reliable agent of this class, and since it was condensed into a liquid form by Bérthelot it has become also one of the most convenient. It can also be obtained now at a comparatively low price from the by-products of distilleries.

A number of attempts have been made to render the method of using it more simple than it was in 1882, when Dr. Lailler, of Paris, constructed a péculiar receptacle for holding it, and M. Ledentu used this apparatus to produce local anæsthesia in a number of minor operations at the Hospital Saint Louis, in Paris.

The latest worker in this field is M. Charles Bailly, of Chambly, who has devised a plan of securing anæsthesia by the application to the part of tampons, made of cotton and floss silk and covered with silk gauze, which have been impregnated with chloride of methyl. This impregnation is effected by projecting a spray of chloride of methyl upon the tampon, or by soaking the tampon in the liquid. The greatest merit of these tampons is the fact that they hold the liquid better than any absorbent which has yet been used. In applying them, the tampons are held in forceps made of wood or ebonite, which materials are poor conductors of heat. The process which M. Bailly has devised he calls by the name of "Stypage." In order to manage the liquid chloride of methyl, Bailly has designed a simple apparatus, to contain and convey it, composed of a glass tube about five inches long sealed in a test-tube in such a way that the tube is in a vacuum produced with an air-pump or by means of carbonic acid and potassa. With this apparatus the liquid can be easily carried about, and used to impregnate the tampons. These are applied directly to the part to be anæsthetized, and can be used in such a size and for such a length of time as is exactly suited to the purpose intended. Bailly has carefully studied the effects produced by this method, and has recently (January, 1888) reported them to the Académie de Médecine, which has just received the report of a Commission endorsing the views of M. Bailly. The latter states that an application of one or two seconds

produces local stimulation, followed by a reactive congestion. If the tampon be applied for a little longer time it produces a marked local pallor and commencing anæsthesia. Prolonging the application for a few seconds more produces whiteness and stiffness of the skin, and an anæsthesia sufficient for minor operations. A still longer application produces blistering, and even an eschar, due to absolute freezing.

The varying results secured in this way have suggested a variety of therapeutical uses for this method, in addition to the production of anæsthesia for surgical purposes. all of which are described by Bailly in his paper published in the *Gazette Hebdomadaire*, Feb. 3, 1888, and by the Commission referred to, in its report, published in the *Bulletin de l'Académie de Médecine* for Jan. 31, 1888. We have not space in which to go into the details of the therapeutic indications for "Stypage," to which we may refer at another time; but we desire to call the attention of our readers to it, as we believe it is likely to prove more than a mere novelty in practice. If half the hopes of its inventor, and of his French colleagues are realized, it has a large field of usefulness before it; and it is well that American physicians and surgeons should be informed as to its possible applications and test its merits for themselves.

Book Reviews.

[Any book reviewed in these columns may be obtained, upon receipt of price, from the office of the Reporter.]

PROTOBIOLOGY; OR, THE PHILOSOPHY OF LIFE. By Joseph McEwen, M.D., 8vo, pp. 101. Philadelphia: Phillips & Williams, 1887.

In the preface of this little book, the author asks for indulgence, on the ground of sincerity, and states that if his design falls short of the purpose intended it will not be for lack of purity of motive, but for lack of judgment. Such an announcement almost disarms criticism. But, having examined this book with some care, we have failed to discover what use it can be put to. It is straightforward, and may be clear to the author; but, to be candid, we cannot make out what it means. This may be our fault or misfortune, but it is a fact.

THE CHILDREN OF SILENCE; OR THE STORY OF THE DEAF. By Joseph A. Seiss, D.D., LL.D. 8vo, pp. 208. Philadelphia: Porter & Coates, 1887.

The author of this book, besides being a clergyman whose preaching has proved acceptable and useful to a large number of people, is one of the Directors of the Pennsylvania Institution for the Deaf and Dumb. His book has grown out of studies undertaken to fit him to discharge his duties at this institution intelligently. It was an admirable idea to give others the benefit of these studies, and the example Dr. Seiss sets is one which other managers of public institutions might well follow. If all such men made such thorough studies of the objects of their charitable labors, the result could not but be in the highest degree beneficial.

Having said this much as to the spirit of the author of this book, we have but little space left in which to speak of its character. This may be described, however, as most admirable. The whole subject of the nature, causes, manifestations and treatment of deafness, and of deaf-mutism is thoroughly discussed, and in a manner as attractive as it is instructive. One rises from a perusal of the book with an increased sympathy for the unfortunate class it treats of, and a clearer understanding of what may be done to relieve their sad condition.

TRANSACTIONS OF THE AMERICAN DERMATOLOGICAL ASSOCIATION. Eleventh Annual Meeting, 1887. 8vo, pp. 49. Boston: S. J. Parkhill, 1887.

The proceedings of the American Dermatological Association are interesting reading. One of the most interesting papers presented at this meeting was that of Dr. J. E. Atkinson, of Baltimore, on "Erysipelas in Infants," which led to a discussion which indicated that the disease is not contagious, or, if it is, only in a very limited way. Dr. James C. White, of Boston, also stated that for the past four or five years he has given no internal remedies in the treatment of erysipelas, and has never seen a case in which the eruption did not disappear in four or five days. Dr. J. Nevins Hyde, of Chicago, endorsed this pratice. Dr. Atkinson believes in using the tincture of the chloride of iron.

Among other interesting papers presented was one on "Dermatitis Herpetiformis" by Dr. L. A. Duhring, one on "Medicated Rubber Plasters" by Dr. H. W. Stelwagon, and one on "Salt Baths" by Dr. Henry G. Piffard.

TRANSACTIONS OF THE AMERICAN GYNECOLOGICAL SOCIETY. Vol. 12. For the Year 1887. 8vo, pp. 512. New York: D. Appleton & Co., 1888. Price, $5 00.

It would be impossible, in the space at our disposal, to give any idea of the contents of this handsome volume, which, like its predecessors, is a monument to the executive and literary ability of the Fellows of the American Gynecological Society. This Society is one which reflects great credit upon the medical profession in America, and contributes to making our country foremost in every effort for the amelioration of the lot of suffering woman-kind.

THE RULES OF ASEPTIC AND ANTISEPTIC SURGERY. By Arpad G. Gerster, M.D., Professor of Surgery at the New York Polyclinic, etc. Illustrated with two hundred and forty-eight engravings and three chromo-lithographs. 8vo, pp. xii, 332. New York: D. Appleton & Co., 1888. Price, $5.00.

The title of this magnificent book gives no adequate idea of its contents. It contains, in fact, not only an admirable account of the theories and certain methods of aseptic and antiseptic surgery, but also a detailed description of the mode of procedure in a large

number of surgical operations, and of the appliances used in their after-treatment. The methods of operating are those most approved by the best surgeons living, and are described in a thoroughly lucid manner. The surgical applicances recommended reflect equal credit upon the learning and ingenuity of the author, who goes into details which are useless to no surgeon, and may be of the utmost service to any who are not familiar with the great advances which have been made in this part of surgical work within the last few years.

Dr. Gerster's book does not cover the whole field of surgical practice. For example, it does not discuss the treatment of injuries or diseases of the skull and of its contents; but it does treat of various phases of operative surgery of the limbs, of the abdomen, of hernia, of tumors of the breast and neck, as well as of the treatment of gonorrhœa and syphilis. These various subjects are considered systematically, as far as is consistent with the main object of the book, which is to teach the method of aseptic and antiseptic surgery.

It is no small addition to the value of the text of Dr. Gerster's book that the illustrations of it are of a very high order of excellence. Most of them are reproductions of photographs by the phototypographic method, and wonderfully handsome and instructive. The work of the publishers, in preparing this book, is as creditable to them as is that of the author to him, the paper, printing and binding being of the very best quality; and we can and do recommend it very strongly to our readers, as we feel that it is a book which ought to be in the hands of every practicing surgeon.

Pamphlet Notices.

Shakespere and the Medical Sciences. By L. M. Griffiths, M.R.C.S. Eng. L.R.C.P. Ed. From the *Bristol Medico-Chirurgical Journal*, December, 1887. 32 pp.

Suicide in its Relation to Insanity. By John J. Reese, M.D. etc., Philadelphia. From the *Medical News*, January 21, 1888. 15 pp.

The Physiological Action of Kreatin, Kreatinin, and their Allies. By Thomas J. Mays, M.D., Philadelphia. From the *Practitioner*, vol. xxxix, No. 4. 8 pp.

The Treatment of Pulmonary Consumption, with a Report of Forty Cases. By Thomas J. Mays, M.D., Philadelphia. 16 pp.

The Differential Action of Brucine and of Strcyhnine. By Thomas J. Mays, M.D., Philadelphia. From the *Journal of Physiology*, vol. viii, No. 6. 13 pp.

Synopsis of the Second Hundred Cases of Urethral Stricture Treated by Electrolysis. By Robert Newman, M.D., New York. From the *Journal of the American Medical Association*, September 24, 1887. 15 pp.

—Mr. Griffiths' paper is his Presidential address at the fourteenth session of the Bristol Medico Chirurgical Society. It is not quite what would be expected from its title, as the author acknowledges in a short preface; but it contains a number of very interesting facts in regard to the medical characters alluded to by Shakespere. In the introductory portion Mr. Griffiths indulges in some general reflections, one of which is a rather severe, but not wholly groundless condemnation of which is called "collective investigations."

—Dr. Reese, in the course of his general experience and in his work as Professor of Medical Jurisprudence and Toxicology in the University of Pennsylvania, has had abundant opportunity to familiarize himself with such questions as the one he discusses in this pamphlet. In it he presents the reasons which seem to him to show that the act of suicide is not in itself an evidence of insanity, and that the common verdict that suicide is the result of temporary aberration of the mind is a charitable euphemism. The argument is convincing and the pamphlet is one of great interest and value.

—In 1886 Dr. Mays reported to the College of Physicians of Philadelphia the results of his study of the nutritive properties of certain beef-extracts and has followed this up with an attempt to ascertain what part of their nutritive property is to be attributed to their organic extractives. The pamphlet before us contains the results of his study, which lead him to attribute the nutritive value of beef-extracts to their contained kreatin, kreatinin, etc. We can heartily commend this essay to the consideration of all who are interested in this important physiological problem.

—The pamphlet of Dr. Mays on consumption, contains his address before the Medical Society of the State of Pennsylvania at its meeting in 1887, and presents briefly the author's views as to the nature and proper treatment of pulmonary phthisis. It may startle some of those who read his address to find how small a part of the cases of consumption Dr. Mays seems to attribute to tuberculosis; and others may wonder at a report which states that thirty-one patients with consumption recovered under a method of treatment here described.

—Dr. Mays' paper on Brucine and Strychnine contains the results of an investigation to determine whether the difference of pathological action caused by administration of these two alkaloids is one merely of degree, or of kind. Dr. Mays thinks that this difference is one of kind. The experiments which lead him to this conclusion are described in detail, and seem to justify it.

—Dr. Newman is an enthusiastic believer in the sufficiency of electrolysis for the cure of stricture of the urethra. The reprint before us contains an address delivered at the meeting of the American Medical Association, in 1887, which made a decided impression upon all who heard it. Dr. Newman describes results from his plan of treatment which explain the earnestness with which he pleads that it ought not to be sneered at; and, least of all, by those who have no experience in the use of electricity. It is true that want of personal experience does not necessarily unfit one to judge of a method; for if it did few could condemn garroting, or the practice of hari-kari. But the application of electrolysis to the treatment of stricture of the urethra ought not to be condemned by those who have not tried it, in the face of the claims made for it by those who have, unless it can be shown that what its defenders say is erroneous in point of fact.

—The *Pallmall Gazette* says that the Murchison medal of the Geographical Society of London, is to be awarded this year to Prof. J. S. Newberry, of Columbia College, New York.

Literary Notes and Queries.

[In this column the Reporter will publish short items of literary interest and questions addressed to this Journal or its readers, and answers to them, in regard to any literary matters: books, authors, places and prices of publications, etc.]

—With the number for February, 1888, the title of the *Mississippi Valley Medical Monthly* was changed to the shorter, more distinctive and better one of *Memphis Medical Monthly*. The fact which we record furnishes us with a welcome opportunity to express our appreciation of this excellent journal and to wish it continned and increased success.

—The *Quarterly Review of Narcotic Inebriety* is an octavo, the first number of which is dated January, 1888, and contains twenty four pages. It is edited by Dr. J. A. Loveland, Gilsum, N. H.; price, $1.00 a year. It is devoted to the subject indicated by its title, and gives promise of usefulness. The number before us bears strong testimony to the propriety of treating morphinomania by rapid diminution and speedy withdrawal of the doses of this drug.

—The *Albany Medical Annals* began its ninth volume in January, 1888, and appeared in a new form and considerably enlarged. From having been merely a Bulletin of the Medical Society of the County of Albany, N. Y., it now becomes a general medical journal, to be issued monthly; price, $1.00 a year. The contents of the first two numbers for the year are interesting; and we wish it success.

—*Book Chat* is a twenty-four-page magazine, published monthly by Bretano's, New York; price, $1.00 a year, each number containing a certain number of extracts from new books, a catalogue of new publication, and a classified index of current periodical literature.

—*The American Anthropologist* is a new journal published under the auspices of the Anthropological Society of Washington, D. C., forming the continuation of its "Transactions." It is to be issued quarterly; price, $3 00 a year. The first number, dated January, 1888, contains sixty-nine octavo pages, and four original articles.

—The first number of the *Petite Revue d Obstetrique et d'Hygiène du Premier Age*, was issued in Paris, January 29, 1888.

Correspondence.

Quick Getting-up after Confinement.

Editor Med. and Surg. Reporter:

Sir:—The *Boston Medical and Surgical Journal* has been reporting some remarkable cases of speedy recovery after childbirth, and I would like to report one which occurred in my practice.

In May, 1883, Mrs. T., who expected to be confined early in June, made arrangements to move with her family, a husband and two small children, from Danvers, Mass., to a town in Maine, one hundred and seventy-five miles distant, expecting to get settled there before her confinement. On the 19th their goods were all packed and sent to the railroad station, and they were ready to start on the first train the next morning. A borrowed mattress, laid on the floor, afforded lodging for the night. At two o'clock in the morning labor came on, and I delivered the woman at 7 o'clock, after a painful confinement. Before I took the placenta away, she said: "I have been cheated out of going today; but I will go to-morrow." The afterpains were so severe that I was sent for, and had some difficulty in relieving them. In the afternoon I found her dressed and sitting up, but crying bitterly. Supposing she was still in pain, I was about giving her another dose of anodyne, when she said she was not suffering. After a while I found that the cause of her grief was that her husband was drinking. I intended visiting her early the next morning, and if any attempt was made to go, I would prevent this. I was a few minutes too late, however, and found that the bird had flown, with her drunken mate and all. I afterwards learned that she reached her destination at 6 P.M., having traveled all day. The next year she was back in Danvers, with her three children and husband, looking as young and fresh as ever. She has had one or two children since, and is now living in this town.

Yours truly, W. G. Frost, M.D.

Danvers, Mass.,
Feb. 15, 1888.

Remarkable Treatment for Elongated Uvula.

Editor Med. and Surg. Reporter:

Sir:—Enclosed find a slip of paper, written by a colored man of some education. I showed it to a colored doctor who can't read or write, but who practices under the ten year law, regulating the medical profession of Indiana; said doctor told me that he cures such cases by taking the longest hair on top of the head, and pulling the throat and soft palate up to the roof of the mouth, after which he ties both with a silk thread to the last vertebral bone, keeping them there till the throat and palate become systemized in their proper place, when the patient is sound and well. Then he cuts the thread from the bone, and the hair close to the scalp. Yours truly,

Evansville, Indiana. J. Pirnat, M.D.
Feb. 4, 1888.

Spurious Hydrophobia.

Editor Med. and Surg. Reporter:

Sir:—I was greatly pleased with your editorial on hydrophobia in the Reporter for December 24. I am of the same opinion as

to the rarity of genuine hydrophobia, if there be such a disease; and it calls to mind a case which was also alleged to be hydrophobia. A young man of this city was bitten by a dog long known to be cross and surly, and was soon afterward shot. The story now spread that the dog was mad. In a short time the young man began to act strangely; was unable to eat or drink, had spasms, barked like a dog, etc. I did not see him at the time, but several physicians of this city saw him, and it was alleged that he was mad; one or two specialists from New York also came up to see him. Two or three years afterward I became acquainted with him, and attended his family for a time, and he then told me how he was treated. He said every one was afraid of him, and he was kept under the influence of morphine and ether to such an extent that he hardly knew what he said or did; finally, some one gave him a large emetic, followed by a powerful dose of physic, and he rapidly recovered. He has since left the place; but I shall try to get the full details of this case, as it is one more in the long list of fabulous cases of hydrophobia. He would undoubtedly have died, if he had not been relieved in the way that he was.

Yours truly, C. L. Dodge.

Kingston, N. Y.,
February 11, 1888.

Electrolysis instead of Oöphorectomy.

Editor Med. and Surg. Reporter:

Sir:—Because of the conservatism with which many physicians regard the removal of the ovaries, as well as the risks attending this surgical measure, I wish to ask the profession, through your columns, if *electrolysis* may not be resorted to for the purpose of destroying the functions of these organs, when not affected by diseases which would preclude this operation—if there be any such diseases.

If this less heroic measure proves as effectual as, and more safe than recourse to the knife, multitudes of women will be restored to health, now doomed to lives of chronic invalidism. This class includes, *First*, Those whose sufferings are directly due to the performance of the functions of the ovaries. *Second*, Those who, being invalids, are held to this condition by the depressing influence exerted by menstruation. *Third*, That very large number of women whose distressing symptoms are legion *during the establishment* of the menopause.

In view of the fact that in the majority of cases medication not only fails to relieve, but when constantly used has a deleterious effect on the general health of the patient, I am desirous of learning the opinions of gynecologists in relation to this method of treating the ovaries in order that a cessation of their functions may be effected and the patient be cured.

Yours truly,
H. Augusta Kimball, M.D.

Philadelphia,
February 20, 1888.

Removal of Duty on Instruments, etc.

Editor Med. and Surg. Reporter:

Sir:—At the annual meeting of the Georgia Medical Society, held January 3d, 1888, the following resolution was unanimously carried:

Resolved, That the corresponding secretary enter into correspondence with the medical journals of the country, in order to enlist their influence in support of the movement to remove the import duties from all medical and surgical instruments and appliances, including those used in the diagnosis as well as treatment of disease, so that they may be furnished to those needing them at the lowest possible price.

In compliance with the above resolution, I wish to solicit your earnest attention and a notice in your publication, which will claim the attention of your readers, hoping that your country readers, especially, will appreciate the truth and importance of our proceedings. Perhaps the statement of a few facts will assist the reader in realizing the extent of the grievance and the justice of the plea for which we ask co-operation.

First. Physicians are at the mercy of instrument makers in regard to price, make and quality of finish, because of the lack of sufficient competition.

Second. The price of instruments made in this country is out of proportion to that paid for similar instruments on the continent of Europe.

Third. Surgical instruments and appliances are so costly that but few doctors entering the profession can provide themselves with an outfit adequate to carry on a general practice. At present prices it is impossible for a country physician's income to sustain his investing in costly instruments, and as a result many simple cases, such as retention of urine, foreign bodies in nose or throat, deep-seated abscesses, etc., all of which could be relieved at once with the proper instruments, must either die from the immediate cause or from the effects of time lost in seeking skillful manipulation, or else they are frequently crippled and disfigured, because

the most intelligent help, though patiently given, is itself crippled for want of proper instruments.

Fourth. The cheaper grades of instruments are either antiquated or so poorly made that they may prove a cause of failure in operations, sapping, as it were, the natural inclinations to surgery in its inception.

Fifth. European instruments are from 25 to 75 per cent. cheaper than ours, and their introduction into the market will enable the mass of doctors to buy those of prime necessity, will bring down the price of home-made appliances, and oblige the makers to use good material and put a better finish to their work.

Sixth. The removal of import duties on surgical and other instruments used by the profession, and on medicines in general, will produce the same results as we all know it did on the article of quinine.

Respectfully, J. C. LeHardy,
Cor. Secretary Georgia Med. Society.
Savannah, Ga., January, 1888.

Notes and Comments.

The Results of High License in Chicago.

In a letter to Mr. John B. Pine, of New York, published in the *N. Y. Evening Post*, February 17, 1888, Mr. William J. Onahan, of Chicago, says:

"I send you the desired table of statistics of arrests by Chicago police for a number of years past, as shown in annual report of Police Department. I am informed that journals in New York hostile to high license have attempted to demonstrate that high license in Chicago is a failure—that far from aiding to diminish drunkenness it has on the contrary served only to increase the evil; and that arrests from this cause—"drunkenness"—have increased enormously under the operation of high license. I am justified in saying that no one could be found bold enough to publish this statement in Chicago. These assertions are not true in fact; neither can they be justified as an inference from any collocation or manipulation of figures, official or otherwise. The substantial and incontrovertible fact is that high license has arrested the multiplication of saloons in Chicago—that whereas in 1882–3, under a license of $52 per year, we had 3919 licensed saloons; in 1887–8 the number is substantially no greater, while the population has increased from 500,000 to 900,000, and the city has extended its limits on every side, so that it is not unreasonable to assume we should now have 6000 or more saloons except for the intervention of a high license. Neither is it true that drunkenness has increased out of all proportion these years, as it is claimed the arrests show. They show no such thing. In fact the police reports for several years do not show arrests under the distinctive head of "drunkenness" or "drunk and disorderly" at all. Arrests made for these offences are included under those of "disorderly conduct," which embraces a variety of other offences as well. Plainly, therefore, any use of the figures such as suggested would be misleading, and certainly cannot be sustained. Moreover, I have the authority of the General Superintendent of Police to corroborate my statement in this regard.

No, high license is not a failure in Chicago. It has driven out of existence the pest of the home, the curse of the family—the bar in the family grocery, which is no longer seen here. Very many of these places never had licenses at all. High license checked at once the extension and multiplication of the saloon traffic, and it is no secret that the results in favor of high license would have been far more marked had the law been enforced and carried out according to its plain spirit and intent. Had the license fee, $500, been made payable in advance in one payment, instead of in three-period payments, I am persuaded that the number of saloons would have been down to below 3000.

High license produces a revenue (nearly two millions) more than sufficient to cover the entire outlay for our police.

High license has aided in lifting us out of the quagmire of saloon politics, though much yet remains to be done in order that our emancipation may be complete. But high license will not do everything, nor is it alone the cure for the evils growing out of the drink plague.

High license diminishes temptations, lessons opportunities to drink, and to that extent is a boon and a blessing, but it does not remove the appetite for drink. This latter is to be effected by moral suasion, by religious teachings, through the influence of example. As a citizen I regard "high license," coupled with strict regulation of the saloon traffic by the municipal authorities, as an important auxiliary in the work of temperance reform, as an aid towards better government of cities, and I hail with satisfaction any and every reasonable effort to level upwards in this direction. Finally, I can say without fear of successful contradiction, that the people and press of Chicago are on the side of high license, and if there is to be any change here,

it will surely be towards higher license and stricter regulation for the saloon taffic.

A New Deodorizer for Iodoform.

Louis Genois writes to the *Medical News*, February 18, 1888, advocating the use of purified naphthaline as a deodorant for iodoform. He declares that it will mask the characteristic odor of iodoform so effectually as to challenge detection by the sense of smell alone. He suggests the following formulæ:

℞ Naphthalini purificat.....gr. viiss
Turmeric .....gr. iss
Iodoformi.....gr. xci
Rub together until thoroughly mixed.

℞. Iodoformi deodorat (as above).. ..ʒii
Olei amygdalæ.....fʒii
Lanolini.....ʒvss
M.

For ordinary pharmaceutical purposes the deodorized iodoform can be used instead of the simple drug, but in making an ethereal solution the turmeric should be left out, as it is not soluble in ether.

Formula in Bright's Disease.

Semmola's formula for albuminuria dependent on nephritis, is:

℞ Sodii iodidi.....gr. xv
Sodii phosphat.....gr. xxx
Sodii chloridi .....gr. xc
M. Sig.—Dissolve in water, and give in the course of twenty-four hours, either alone or with milk.

Emulsion of Terebene.

Mr. J. W. England recommends the following formula in the *Amer. Journal of Pharmacy*, February, 1888:

Terebene,.....
Ol. gossyp. sem.....āā ♏clx
Pulv. acaciæ ..... ʒvj
Pulv. sacchari..... ʒij
Aquæ q. s. fiat..... fʒiv
Dose—1 to 2 teaspoonfuls (=10-20 drops).

The product is a milk-white, perfectly suspended liquid, having the odor, and bitter turpentine-like taste of terebene, and is miscible with water, without separation.

This method, of previously admixing with cotton-seed oil is very useful in suspending volatile oils, especially the oils of gaultheria and eucalyptus, which have come into such general use within the past year, and it is more economical, in that a much less quantity of acacia is necessary for suspension, but it is of no value whatever in the emulsification of such liquids as ether and chloroform, so that we are compelled to fall back in their administration, upon previous admixture with milk, as each dose is given; a temporary expedient only, possibly, but one which has certainly yielded good results.

NEWS.

—The *Lancet*, Feb. 11, 1888, reports the death of Dr. Hyacinthe Sauveur, Emeritus Professor in the University of Liège, and last survivor of the old Faculty of Medicine reorganized in 1835.

—By the will of the late Dr. Robert Nebinger, of Philadelphia, a sum of money estimated to be about $300,000 is bequeathed to the Sisters of the Order of St. Francis, for the erection and maintenance of a hospital.

—The number of hospitals in Paris, remaining under the care of religious orders is steadily diminishing. It is said to be the settled policy of the Municipal Councillors to substitute lay nurses for the nuns who have heretofore had charge of the nursing. In accordance with this policy the Augustinian nuns have just been expelled from the Charité Hospital.

—An attempt was recently made in Dublin to photograph a lioness with the head of the tamer in its mouth. The animal, wearied by the tension of her maxillary muscles, or scared, it may be, by the sudden flash of the magnesium light, tore the woman's cheek completely open. Fortunately, no more serious injury resulted, the lioness being beaten off in time to prevent a threatened catastrophe.

—The third Congress of French Surgeons will be held in Paris from March 12 to March 17, 1888. M. Verneuil will preside. The principal subjects for discussion will be 1. The methods of treatment of gun-shot wounds of the viscera. 2. Value of the radical operation for hernia as regards permanent cure. 3. Chronic pleural effusions and their operative treatment. 4. Recurrence after operations for tumors—its causes and prevention.

—The department of general and orthopædic surgery, of the Philadelphia Polyclinic has been reorganized as follows: Professor, H. Augustus Wilson, M.D.; Adjunct Professor, A. B. Hirsh, M.D.; Chief of Clinic, J. F. Bower, M.D.; Assistant, William S. Shimer, M.D.; Mechanician, Mr. A. Gustaf Gefvert. Massage and Swedish Movements, Mr. K. W. Ostrom, from the University of Upsala, Sweden; Miss Anna Jonsson, graduate of the Royal Central Gymnastic Institute of Stockholm, Sweden. A machinist's work shop, with all the necessary tools has been fitted up in the college building, so that the fitting, applying and altering of surgical-mechanical appliances can always receive the combined attention the of surgeon and mechanician. The wards of the hospital afford facilities for cases requiring house treatment.

HUMOR.

THE EMPEROR OF BRAZIL wears a horse-chestnut tied to his neck to keep off evil spirits, and it has been a great success.

PASSENGER (on street-car, alarmed)—"Madam, do you feel a fit coming on?" Madam (haughtily)—"No, sir; I'm trying to find my pocket."

THE AUGUSTA *Chronicle* has invented a way for people to remember what a cold-wave flag looks like. The *Chronicle* says "the flag has a black lozenge in the centre; this is for bronchitis."

WIFE (looking up from her book)—"You know a great many things, John. Now, what do you think should be done in a case of drowning?" Husband—"Have a funeral, of course."—*Boston Courier.*

DR. PELLET—"So Scalpel set your broken arm?" Patient—"Yes, sir." Pellet—"What were his charges?" Patient—"Twenty dollars." Pellet—"Robbery, sir—downright robbery! I'd have amputated it for $25?"

"I WONDER WHERE they get camphor gum?" said little six-year-old Eddie Post. "Why, laws 'ee! Don't you know that? and you in the first reader, too?" replied his playmate, Nellie Green, aged five. "Well, I tell you. You see the Arabs chases the camphors over the deserts till they catches 'em; an' they knocks 'em down an' cuts their gums off."

OBITUARY.

SAMUEL HEY, F.R.C.S., ENG.

Mr. Samuel Hey, of Leeds, England, died February 21, 1888, aged 73 years. He was the fourth link in a chain which has stretched in one unbroken line for 150 years, and which has inseparably bound together the name of Leeds and the practice of surgery. To his predecessors in the surgical world Leeds owes much of the great surgical reputation which she enjoys all the world over, and in Mr. Samuel Hey they were followed by a worthy successor.

JOHN K. KNORR, M.D.

Dr. John K. Knorr died February 15, 1888, at his late residence, in Philadelphia. He was born at Rising Sun, and commenced active life by teaching school. Soon after he entered the medical department of the University of Pennsylvania, from which he was graduated in 1835. Since then he had been actively engaged in the practice of medicine. While prescribing for a patient in his office, he fell dead. He was 76 years old at the time of his death, and leaves three children, two sons and a daughter.

JAMES CRAIG, M.D.

Dr. James Craig was born in the city of Glasgow, Scotland, January 22, 1834. He came to the United States when seventeen years old. He entered the office of Dr. J. H. Stewart, of St. Paul, Minn., where he prosecuted his studies for about two years. In 1859 he came to New York, and matriculated in the medical department of the New York City University, and was graduated therefrom in 1861. He began practice in the spring of 1861 in Jersey City, where he remained actively engaged until within a few days of his death. His specialty was obstetrics, in which he was very successful. He leaves five of his family, three daughters and two sons. Dr. Burdette Craig, the eldest of the family, succeeds to his father's practice.

D. MAY, M.D.

Dr. D. May, died in Findlay, Ohio, February 16, 1888. He was a practising physician in Fairfield county before the war of the rebellion, and had a wife and two children when he left, in 1861, to join the Union army. His long absence led his family to believe him dead, and his wife remarried. Upon the death of his wife Dr. May returned to Ohio and made himself known to his children. Dr. May was a resident of Findlay for many years and was well known all over Ohio.

SENECA B. THRALL, M.D.

Dr. S. B. Thrall died in Ottumwa, Iowa, January 20, 1888, at the age of 56 years. He began the study of medicine with his father in 1849. He was a member of the Iowa State Medical Society, and its Secretary from 1870 to 1877.

No changes in the Medical Corps of the Navy, during the week ending Feb. 25, 1888.

Official List of Changes of Stations and Duties of Medical Officers of the U. S. Marine Hospital Service, for the two weeks ended Feb. 25, 1888:

L. L. Williams, Passed Assistant Surgeon, promoted and appointed Passed Assistant Surgeon from Feb. 10, 1888. Feb. 23, 1888.

J. O. Cobb, Assistant Surgeon, appointed an Assistant Surgeon, Feb. 21, 1888. Assigned to duty at Marine Hospital, Chicago, Ill., Feb. 25, 1888.

J. B. Stoner, Assistant Surgeon, appointed an Assistant Surgeon, Feb. 21, 1888. Assigned to duty at Marine Hospital, New York, N. Y., Feb. 23, 1888.

A. W. Condict, Assistant Surgeon, appointed an Assistant Surgeon, Feb. 21, 1888. Assigned to duty at Marine Hospital, Chicago, Ill., Feb. 23, 1888.

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Clinical Lecture.

CONSUMPTION.

BY JOHN A. ROBISON, A.M., M.D.,
PROFESSOR OF MATERIA MEDICA AND THERAPEUTICS, WOMAN'S MEDICAL COLLEGE; ATTENDING PHYSICIAN TO COOK COUNTY HOSPITAL, ETC., CHICAGO, ILLINOIS.

[Reported by William Whitford, M.D.]

Gentlemen:—We have to-day a group of cases which exhibits the various manifestations of consumption. It is a disease that assumes varied forms. The case before you is one of incipient phthisis, and we commence with him first simply because we desire to make a few remarks with reference to the diagnosis of these cases in their various stages. In the first place, I will state that when you examine a patient, suspecting lung trouble, there are certain precautions which you must observe, to prevent an error in diagnosis. For instance, you must remember this fact, that you will not hear the expiratory sound in all cases. It is only in about three-fourths of the cases that you can hear any expiratory sound. Another point is the relation in the length of time between inspiration and expiration, which varies in different patients. Expiration is usually one-fifth as long as inspiration. You find, sometimes, cases in which the expiratory sound is one-third to one-fourth as long as the inspiratory sound. Now, as a matter of fact, expiration is really four-fifths as long as inspiration, because it takes nearly as long to expel the air from the air-cells as it does to fill them. But there is a great difference between inspiration and expiration as regards the length of time these acts occupy, so far as your sense of hearing is concerned; consequently when you listen over the chest you will find you can generally hear inspiration quite readily, while expiration is not so readily heard, and does not occupy the whole length of time during which the air is passing out of the lungs. If we represent by figures the length of time which inspiration and expiration occupy, as well as the period of rest, they would stand in about this ratio: Inspiration occupies five-tenths of the time; expiration about four-tenths of the time, and then there is a pause between expiration and inspiration, which is the period of rest, occupying about one-tenth of the time. But on auscultation these figures would be changed, as expiration would appear to be three or four times longer than inspiration. And you must remember that patients do not follow test figures. You may meet persons who have sound lungs and the expiratory sound is nearly as long as the inspiratory. Therefore, do not be too ready to base a diagnosis of there being pulmonary disease present when there is prolonged expiration.

There is another point, and that is to determine the *quality* of the expiratory and inspiratory sounds. The inspiratory sound is a soft, breezy, low-pitched sound. When you listen over the chest and hear it, it gives you the idea of a soft current of wind passing through the chest. On the other hand, you are taught that the expiratory sound is higher in pitch. By some authorities it is claimed to be lower in pitch. If you will listen carefully over a healthy chest you will find that the difference between the expiratory sound and the inspiratory sound is this: The inspiratory sound is soft, breezy or vesicular in quality, and low-pitched, while the expiratory sound has less vesicular quality, is more like a blowing sound, with a lower pitch. Whenever you find a case in which the expiratory sound is longer than the inspiratory, and its pitch is high, and its quality blowing, you may be certain it is due to consolidation of lung tissue.

There is one point I wish to mention, and one that is not often referred to, and yet you would learn it yourselves by practice, and that is the presence of a sound from a peculiar muscular vibration which takes place, especially during inspiration, in the muscles of the chest wall. This sound is termed muscular susurrus, a word which indicates the vibratory sound. This sound approximates somewhat in character the inspiratory sound. It is a soft, low-pitched, wavy sound, and listening over the chest wall in patients who take a full breath or exert themselves, you may be inclined to think you hear the inspiratory sound and may mistake it for the respiratory sound, and may think it evidence of a healthy lung, when in reality broncho-vesicular breathing may be present. The way to prevent that is to have your patient breathe easily, or do not let him take full breaths, so that you may be able to hear the respiratory sound without this muscular vibration. You may also prevent it to a certain extent by placing the muscles in a state of relaxation. The ordinary direction in examining the chest is for the patient to place the muscles of the region being examined in a state of tension; for instance, if you are listening over the anterior portion of the chest, have the patient place his hands behind his back. By so doing you get a more pronounced susurrus. In case you get this sound simply have your patient place himself in some other position, so as to put the muscles in a state of relaxation.

This patient, a male, aged 22, an Italian, and a laborer, has been ailing one year. He says he has had a hacking cough, has lost flesh, at intervals has night-sweats, and sometimes is feverish.

The physical signs in this case are flattening of chest at the right apex, loss of motion on the right side, dulness to a slight degree, and increased vocal fremitus over the right infra-clavicular region, with broncho-vesicular respiration. This is a well-marked case of pulmonary tuberculosis in the first stage.

The physical signs you obtain in the first stage of phthisis depend much upon the amount of consolidation of the lung. If there be a limited amount, and the disease is of short duration, there would be very little difference in the conformation of the chest walls; but if the disease has been of quite long standing, and the amount of consolidation is considerable, there is consequently a retraction of the lung tissue, and as a result of that the deprived air-cells become collapsed and that characteristic flattening at the upper part of the apex occurs. Associated with this flattening there is loss of motion because that portion of the lung does not expand fully.

However, you may meet cases in which you get none of these signs, and yet you can, in the majority of such cases, make a diagnosis in the following manner: supposing in this case the only physical sign present was mucous râles over a limited area only on one side; in the absence of injury of any kind to the lung producing localized bronchitis, such as introduction of irritants into the bronchial tubes, you can almost certainly say that the case is one of incipient consumption; and thus a diagnosis could be made before the ordinary physical signs had appeared, and at a time when you could most advantageously place your patient under the proper treatment. I believe there is truth in the statement by Buhl, that bronchial walls often become inflamed, and that this is accompanied by parenchymatous pneumonia in a limited area. Such a condition of the lung tissue would give rise to such signs as I have often noticed in cases which eventuate in consumption of the lungs. This sign is, therefore, a very important one, since it enables us to forecast the future, and being forewarned we can be forearmed therapeutically.

A Case of Acute Phthisis.

This second patient presents the disease in a more advanced form. The patient, a man, is 19 years of age, and was admitted to the hospital February 2, 1888. On admission his pulse was 124; temperature 103°; respirations 30. This morning, February 3, at 3 A.M. his pulse was 124; temperature, 104.2°; respiration, 32. Family history good. As to his personal habits, he drinks moderately. He had pneumonia eleven years ago, but otherwise has been in good health until the commencement of this illness. Present trouble commenced with a severe chill about a month ago, the chill lasting about eight hours, and being followed by a severe headache, cough, dyspnœa and pain in the chest; no blood in the sputum, which has always been yellowish-white and frothy. Bowels have been constipated; has had night-sweats from the commencement of the disease; little or no appetite. On admission, patient appeared emaciated; face was florid; tongue was clean, but flabby; skin dry.

Gentlemen, you will notice that dyspnœa is severe and that cyanosis is appearing, the lips and face being bluish. His tongue has a raw appearance, indicating great debility and fever.

This case exhibits a form of the disease in which the deposit is undoubtedly miliary tubercle, and from the rapidity and shallowness of the respirations both lungs must be thickly studded with them. There is no loss of motion, no dulness on percussion, no bronchial breathing, nor, in fact, any of the signs which indicate consolidation of the lung; but listening over the chest we hear fine subcrepitant râles, with puerile respiration. What does that indicate? It indicates that the bronchial tubes, especially the smaller ones, are inflamed. Then on both sides we can find in two or three different places small friction sounds. What do they indicate? They indicate that miliary deposit has taken place beneath the pleuræ. You notice, furthermore, that the patient complains of having pain in the abdomen. I have no doubt there is also, a deposit of miliary tubercle in the peritoneum. Breathing over both lungs is harsher than normal, shallow and frequent. All these physical signs point to the fact that there is a miliary tubercular deposit throughout the whole lung tissue, involving the pleura, and perhaps the peritoneum, or the serous coats of the intestines.

In this case the symptoms are a high temperature, a rapid pulse, and frequent respirations. The patient has lost flesh rapidly. The history of this case will undoubtedly be this: That the high temperature will continue, no matter what course of treatment may be instituted, and the case will continue to be one of progressive emaciation and exhaustion, finally terminating fatally.*

The method of making a diagnosis between cases of acute phthisis and phthisis due to gray tubercle is very different. In a case of consolidation of the lung, or what is known as "old-fashioned consumption," you make your diagnosis by well-marked physical signs; whereas in a case of miliary tubercle of the lung you make it more from the symptoms than from physical signs.

Phthisis Complicated with Tubercular Laryngitis.

Our next patient was admitted to the hospital February 2, 1888. He had bronchial trouble some years ago. Last year he suffered from mercurialism, mercury having been given him for specific trouble, whence he dates the active onset of his present illness. He became hoarse; at times breathing would be labored, and deglutition painful; sometimes only fluids could be taken. He has a dry cough; no expectoration; has lost much flesh; has nocturnal seminal emissions, diarrhoea, and lately night-sweats. The character of his cough is hoarse and laryngeal, while his voice has almost failed, he not being able to speak above a whisper. On laryngoscopic examination we see there is ulceration of both vocal chords, extending to the anytenoid cartilages. This accounts for the character of the cough. We may get the same kind of a cough in paralysis of one or both vocal chords of the larynx, in cases of ulceration, loss of tissue of the vocal chords, or interference with the action of the muscles of the larynx.

The lesion which exists in the lung in this case is in the form of a cavity in the right apex. The characteristic physical sign is cavernous breathing, which is present in this case in a typical form.

By the way, I should have remarked that his occupation has been that of theatrical singer, and the fact of using his voice every night, and perhaps during the day, and also being exposed to draughts, combined with the ptyalism, no doubt inflamed the latent tubercles, and hastened the full development of the disease.

When ulceration of the vocal chords occurs deglutition is painful and exceedingly difficult. It is more difficult to swallow dry than soft articles of food, and the patient finds it harder to swallow liquids than soft mush, or food of a similar nature; consequently in our treatment we have to order bread soaked in milk, or pudding, or some article of food that has a like consistency.

I read an article in a medical journal some time ago (referring to cases of laryngitis, or ulceration of the larynx, in which patients had difficulty in swallowing) to the effect that the difficulty of swallowing could be obviated by having the patient drink out of a bowl with the head lower than the body. I tried that in the case of a young lady with tubercular laryngitis, and it was a success. I simply had her lean over the edge of the bed, and had her swallow with the head lower than the body, and the result was she could swallow liquids quite readily in that manner. The explanation of it is supposed to be some peculiar action of the muscles and the force of gravity in aiding the closure of the epiglottis.

Cases of tuberculous laryngitis you will meet frequently when you go out to practice; and the question arises, what treatment can we institute for them? I presume there is no subject which has been more written upon by specialists than the treatment of tubercular

* A few days later this patient died, and the miliary deposit was found in the lungs, kidneys, liver, and in all the serous membranes.

laryngitis, and in which the results have been less fruitful in obtaining a treatment that is successful in curing the disease. The only thing we can attempt to do is to institute such treatment as will render the patient as comfortable as possible; and that comfort consists in the first place, in relieving the cough. This you can do by the internal administration of opiates or anodynes, remembering that too much of the opiates will cause dryness of the throat, and that itself is a source of irritation and discomfort to the patient. In the second place, constitutional treatment must be re-enforced by local treatment. The larynx should be cleansed thoroughly every day; oftener than that, if necessary, and at the same time some antiseptic remedy applied—as iodoform, for example—which is indicated, and recommended perhaps more than any other remedy in these cases. To relieve the pain in deglutition, we may apply a five or ten per cent. solution of cocaine shortly before eating. Krause, of Berlin, has extolled highly the use of lactic acid, while Rosenberg, of the same city, speaks in praise of menthol. In the third place, in certain cases, where the disease has progressed very rapidly and suffocation is imminent, the question would arise whether tracheotomy would be justifiable or not. The symptoms must be urgent, and the surgeon must be fully convinced that he will either prolong life or relieve suffering, before undertaking the operation. I do not consider it justifiable in this case at present, and we will therefore follow out simply local medication, being in readiness, however, at any time, to carry out any operative procedures that may be necessary.

A Case of Tabes Mesenterica.

J. L. was admitted January 5. Family history: One sister died of consumption. Two years ago he had an attack of rheumatism, during which time his ankles became swollen. February, 1887, his left leg was amputated on account of tuberculosis of the ankle-joint; he left the hospital in March of the same year, and has not regained his former health. He coughs a good deal, the sputum being of a yellowish color; the lower extremities become œdematous at times; the abdomen enlarges; micturation becomes more frequent; and at short intervals the patient suffers from diarrhœa. When first admitted into the hospital there was enlargement of the abdomen, a good deal of tenderness and diarrhœa at times; and while we are not able to find any tubercular trouble of the lungs, yet at the same time he is progressively emaciating, and the enlargment of the abdomen is increasing. We have no indication of the presence of dropsy. Making deep pressure through the abdominal walls, we can feel what seems to be enlargement of the mesenteric glands. It is one of those cases in which there was primary tubercular trouble of the ankle-joint, for which amputation was performed, and the tubercular disease has now appeared in the mesenteric glands. He has continuous fever, with progressive emaciation.

On the 9th, four days after admission, his temperature was 103.2°; morning of the 11th, 99°; evening, 100.8°. His temperature then remained about 99° or 99.8° until the 22d, when it rose to 100°. On the 25th, afternoon temperature was 100.8°, showing, of course, excessive waste of tissue. The prognosis is unfavorable. The case is an illustration of the manner in which tubercular disease may manifest itself.

Communications.

TYPHO-MALARIAL FEVER, AND QUININE.

BY JAMES W. PRICE, M.D.,

FORT SMITH, ARKANSAS.

For forty years, and most of that period engaged in active practice, I have been a close observer of the various diseases incident to the climate in which I have lived. I speak of the different forms of fever, and from an honest standpoint, I have long since come to the conclusion that they have not changed in grade or symptoms for a century. Typhoid, remittent, intermittent, and inflammatory types are exactly what they were one hundred years ago. Professional views, however, have undergone a wonderful development, and this has resulted in various experiments, not all of which have been to the advantage of the patients; and it is a serious question, whether or not diseases are cured with any greater success than they were in the days of our fathers? This interrogation may arouse the young men of the profession; but, we who have been long in service, and have fought many battles in the professional field, are not so apt to be entrapped by new names of diseases, or the numberless modern therapeutical agents.

I reside in a region where malaria is prevalent, and frightens many people into imaginary paroxysms of so-called typho-malarial fever. This is a form of fever which I should name inflammatory remittent, but our most

progressive medical brethern here insist upon the term typho-malarial. In regards to this, Prof. I. G. Jones, says: "Malaria is a generic term; typho-malaria is a misnomer. Both are calculated to mislead novices, and even old practitioners; therefore, I propose the good old term remittent. If we claim that it is due to miasm, we only plead our ignorance of its causes, as we do not know what malaria is." The term typho-malarial fever is of modern origin. Dr. J. H. Egan states that this title was given to the fever contracted by the U.S. troops in the Chickahominy swamp while investing Richmond. Dr. Woodard, who gave it the name, recanted his position, and regretted that an error should have gone uncorrected for ten years.

Alfred Stillé, Professor of Theory and Practice of Medicine, says: "Remittent or bilious fever, called lake, marsh, or jungle fever, is of all degrees of gravity. The course is made up of a series of paroxysms and remissions, with no intermediate periods of health; the paroxysms may be short, may be long, or almost continuous. Symptoms abate, but do not cease. If the fever tends to recovery, it changes to intermittent; if it tends to death, the patient sinks into the typhoid state. The typhoid state of malaria has been absurdly called typho-malarial fever."

The treatment of so-called typho-malarial fever is almost entirely confined in this country to the indiscriminate administration of quinine, not unfrequently in enormous doses. This error has grown out of the assumption that the disease is of malarial origin. All the cases which terminated fatally, have exhibited hyperemia of the brain, which in in my opinion, was the direct effect of quinine, and not due to the disease itself.

Dr. Atkinson, says: "The use of quinine in full doses in this fever is apt to produce torpor and congestion, attended with a slow pulse, profuse perspiration, inanimation, and a world of trouble to the doctor and danger to the patient."

H. G. Magee, M.D., says: "This fever is not influenced by quinine, so we must come to the conclusion that the name of typho-malarial fever is a misnomer."

Dr. Usher: "Like Dr. Thompson, I have had very poor success when I used and relied on quinine; it seemed to aggravate the case."

Prof. Binz, holds the theory that quinine reduces the temperature by weakening the power of the zymotic poison. He does not deny that quinine may kill by paralyzing the heart.

Peacock of London, and Niemeyer, have both given up the use of large doses of quinine. Quinine in large doses is unnecessary, useless, and often dangerous.

Benj. Edeson, M.D., says: "For some years physicians have been *quinine mad*, affected with what may be termed *cinchoniphobia*. The practice seems to have been, when in doubt, give quinine; give quinine any way. So the people have been dosed with it, and have been educated up to the belief that it is good for every ailment. So the public order it in pills, powders, tablets, and triturates, just as they do their potatoes and flour, and take it without a prescription, but with the *quasi* endorsement of the doctor that should it do no good, it would do no harm."

I cannot close this article without calling attention to the danger of indiscriminate administration of quinine to children, under the impression that it is a harmless agent. It will impoverish the blood by destroying its coloring matter. It is destructive to the nervous system by its powerful impression made upon the brain. Children will become sallow, anæmic, and predisposed to dropsical effusion which will end in premature death.

APEX EXPANSION VERSUS PURE AIR IN PULMONARY CONSUMPTION.[1]

BY THOMAS J. MAYS, M.D.,

PROFESSOR OF DISEASES OF THE CHEST IN THE PHILADELPHIA POLYCLINIC.

Next to the tubercle bacillus, impure air stands most prominent among the many agencies which have been assigned as the causes of pulmonary consumption. Innumerable plans and methods have been devised and proposed for improving the ventilation of our dwellings, hospitals, and workshops; volumes upon volumes have been written on the ill effects of breathing vitiated air; and the immaculate freshness of the country and mountain air has come to be universally regarded as a certain guarantee against pulmonary consumption. These, like many other popular notions, contain a germ of truth, but actually are delusive, inasmuch as they exaggerate the effects of a small evil, and afford a false sense of security against the real source of danger in the production of this disease. This we shall endeavor to show in the following pages.

At the very outset we desire it to be well understood that we do not in the least underrate the value of fresh, wholesome air in the prevention and treatment of pulmonary con-

[1] Read at the Meeting of the Philadelphia County Medical Society, February 22, 1888.

sumption, and while it is probably true that on the whole country people enjoy greater immunity from this disease than city people —though this is not proven on account of a lack of adequate statistics—yet we are convinced that the purity of the atmosphere plays a very small part in bringing about this probable result. If we are permitted to make a homely, hypothetical proposition, we will state that if two individuals who respire the same quantity of air, and who are equally well off so far as heredity, food, clothing, warmth, comfort, etc., are concerned, were both enjoined to maintain a sedentary and a stooped position of their bodies for an unlimited period, one inside of a house and the other outside in the open air, we have no reason for believing that the one inside will fall a victim to this disease sooner than the one on the outside. If it were true that this disease is the result of breathing a vitiated and impure atmosphere, how can we account for the fact that the inhabitants of Iceland, Greenland, Lapland and of other cold countries of the north, who live in dwellings which are notoriously wanting in ventilation, are practically exempt from this disease? Of the Icelanders, Mr. Warford Lock,[1] who is very familiar with these people and who speaks their language, says that their life is "one long exposure to the elements, and during the night they live in dwellings devoid of ventilation, and which, if not buried beneath the earth, are built of turf and often become grass-grown. A very bad feature being the excessive stuffiness of the common living and sleeping-room, when, owing to the absence of fires, the greatest possible crowding and plugging are necessary in order to maintain a tolerable degree of warmth." And yet Dr. Cullimore,[2] from whose work the above quotation is taken, says (p. 73) "that consumption in Iceland is never indigenous, but is always, when it does occur, imported from abroad and but seldom extends to the second native generation." On the other hand, it may be stated that the people of the tropical regions of the globe who enjoy an uninterrupted revelling in pure, fresh air, both day and night, winter and summer, are by no means free from pulmonary consumption. The only difference, so far as the physical life of these two classes of people is concerned, is that the warm climate, which produces such a luxurious atmosphere, also creates a tendency to physiological sluggishness and an indisposition toward physical exertion among its inhabitants; while the people of the cold and rigorous north are compelled to maintain the warmth and vitality of their bodies in great part, by day, through physical exercise, of which their occupations of hunting, fishing, herding, etc., give them a full share. It is also well-known that miners and laborers employed in coal mines, who continually respire an atmosphere which is not only loaded with impurities, but is damp and musty, suffer but very little from this disease.

One fact which lends color to the belief that pure air is such an essential element in limiting the ravages of consumption, is that those who occupy elevated or mountainous regions are less liable to this disease than those who live near the sea level. Thus Fuchs shows from extensive data that "at Marseilles, on the seaboard, the mortality from this disease is 25 per cent.; at Oldenburgh, eighty feet above the level of the sea, it is 30 per cent.; at Hamburg, forty-eight feet above the sea, it is 23 per cent.; while at Eschevege, four hundred and ninety-six feet above the sea level, it is only 12 per cent.; and at Brotterode, eighteen hundred feet above the sea, it is but 0.9 per cent." Carrying this line of observation further, it appears very probable that consumption is almost unknown among any native people who live more than 6000 feet above the level of the sea.

Now that which concerns us here chiefly is the reason why mountain climates are, as a rule, so free from pulmonary consumption. Is it because the atmosphere is pure and free from septic germs? This is hardly possible, for if it were true that the aseptic condition of the air played any very prominent part, why should the Icelanders, who nightly reek in a most filthy atmosphere; or the dwellers along the Nile, who, according to Mr. B. Phillips, live "in huts where the pure air has neither ingress nor egress, except through a small hole near the ground;" or the coal miners, who continuously respire a foul and poisonous atmosphere, all be comparatively free from this disease? Is it due to the general absence of humidity? We think not, for Bogota, the capital of the United States of Colombia, located on the Andes, near the equator, and at an elevation of over 9000 feet, is said to be entirely exempt from this disease, although dampness prevails to quite a large extent. We think there is much reason for believing that it is principally, if not entirely, on account of the attenuated condition of the atmosphere, and shall, therefore, at once proceed to consider the physio-

[1] The Home of the Eddas. S. Low, 1879.

[2] Consumption as a Contagious Disease. Ballière, Tindal, & Cox, 1880.

logical influence of high altitudes on the human body. It is estimated by Dr. Denison that at an elevation of 6000 feet, the surface of the body is relieved of nearly 7000 pounds pressure. When such an enormous weight is lifted from the body it is quite evident that its interior must also be markedly affected —the pulse is accelerated from fifteen to twenty beats per minute; the respiration is quickened from ten to fifteen breaths per minute; evaporation from the skin and lungs is increased, and the amount of urine is diminished. These are some of the immediate effects. Protracted residence in such a high region enlarges the chest capacity. The Quichua Indians, who dwell on the elevated table lands of Peru, have enormous-sized chests, containing capacious lungs with large air cells. The Mexican Indians possess chests which are out of proportion to the sizes of the individuals. Dr. Denison says that children born in the Rocky Mountains have chests of unusually large capacity, and M. Jaccoud states that at St. Moritz the respirations are not only more frequent, but fuller.

The reason why the number of respirations increases while ascending a high elevation becomes clear when we take into consideration the fact that at the sea level a cubic foot of dry air contains about 130 grains of oxygen, while at an elevation of 6000 feet it only contains about 106 grains—nearly twenty-five per cent. less than the body is accustomed to breathe at or near the sea-board—therefore, in order to supply the wanted amount of oxygen to the body, the respirations must either increase in number or in extent. From all accounts it is very probable that respiration becomes accelerated only during the early period of exposure to such an attenuated atmosphere, and that subsequently this function becomes slow again because the air penetrates more deeply and completely into lung tissue but little utilized before.

That man does not suffer under such a deprivation of oxygen is evident from what we know to be true of his lung capacity under ordinary conditions of life. Prof. Mosso has recently proven experimentally that man possesses a lung capacity which is nearly one-fourth larger than the actual necessities of life at the sea level demand; hence by employing his whole lung capacity he can extract a sufficient amount of oxygen from this attenuated atmosphere without difficulty. And herein lies the secret why so many consumptives, and others with weak lungs, derive such a great benefit when they resort to a mountain climate. It may be trite, but it is nevertheless true, that all consumption practically begins at the lung apices, because these parts are habitually inactive. These are inactive because, in the first place, the bronchial tubes are so arranged that they conduct the air with greater facility to the base than to the apex of a lung, and, in the second place, because the lung is larger than necessary; hence the base, which is filled most readily, is filled first, and the apex, if at all, toward the end of inspiration. The apices, therefore, become the superfluous parts of the respiratory organs. It is quite different, however, when the body is immersed in a highly attenuated atmosphere. Every available space in the chest is now brought into requisition to furnish the needed amount of oxygen, the apices are called out of their lethargic state, and the alveoli are inflated, and if the infiltrated areas are not dispersed the surrounding alveoli are kept permeable, and so the disease is, at least, limited and called into abeyance.

This statement is corroborated by those who have had large experience in the climatic treatment of pulmonary consumption. Thus Ruedi reports[1] "that of 600 consumptives under his care at Davos, expansion of the thorax took place in no less than 584." Dr. Denison says[2] "the increased circumference of the chests of consumptives after undergoing the high-altitude treatment is shown in many of Prof. Weber's, as well as in my own cases." Dr. Lindsay, in the work already quoted, states (p. 32) that "Davos does not cure consumption by its sunshine, or the purity and dryness of its air (although these conditions undoubtedly co-operate in the beneficial effect) but mainly by the rarefaction of its air, which stimulates respiratory activity, promotes healthy expansion and soundness of tissue in the lungs, and hence aids them to resist the spread of morbid deposits." So much, then, for the immunity which is afforded by mountain climates; but that which is of still greater interest to us is the fact that those who follow active employment are less liable to this disease than those who pursue sedentary and quiet occupations. Thus M. Lombard found "In Paris, Geneva, Vienna and Hamburg, that there are a greater number of persons leading a sedentary life afflicted with phthisis than of those leading an active life, in the proportion of 141 to 89. In the Brompton Hospital the relative liability was

[1] Climatic Treatment of Consumption. By Dr. J. A. Lindsay, p. 62.

[2] Rocky Mountain Health Resorts, p. 85.

found to be 63 per cent. of indoor males to 30 per cent. of outdoor, and all the consumptive females followed indoor occupations. Dr. Guy found in the close workshops of a printing establishment the compositors, whose employment is sedentary, fell victims to phthisis in the proportion of 44 per cent. to 31½ per cent. of the pressmen, who, although breathing the same air, and in every other respect subject to the same habits of life, differ only in the active bodily exercise which the press imposes on them; and among the same class of operatives the deaths from the same cause did not exceed 25 per cent. in those who use exercise in the open air." (Ancell.)

There can be no doubt, too, that those of our Indians who are still allowed to obey their roaming instincts of hunting and of fishing, or to follow their vocation of farming, which a number have, owe their immunity from this disease, which we know they possess, in great part, if not entirely, to the physical exercise which they obtain in this manner; while those who are subjected to the idle and improvident reservation life die rapidly from it, principally because they are deprived of their wonted exercise. This is of special interest to us here, because it has such a direct bearing on the main point at issue. Some of the former class of Indians, like the Pimas, for example, who may be called wild, although they are agricultural in their habits, are living in half underground huts, with very little or no ventilation, yet, from all accounts, consumption is an exceedingly rare disease among them.

Thus far we have seen that, on the whole, those who occupy elevated habitations, as well as those who follow active exercise, are more exempt from the disease under consideration than those who live near the sea level, or those who live a life of quietude. In connection with this we will consider the influence of physical exercise on the lungs, and endeavor to ascertain how it affords protection against consumption. During physical exercise more oxygen is consumed by the muscles, and more blood and air circulate through the lungs than during rest. Just how much more air enters the lungs during activity than during rest can easily be estimated when it is known that during inactivity a man breathes 480 cubic inches of air per minute, and while walking at the rate of four miles per hour, or while tramping a treadmill, he breathes 2400 cubic inches, and if he walks at the rate of six miles an hour he takes in 3260 cubic inches of air per minute. The difference between 480 and 2400 cubic inches of air capacity shows that during the exercise of walking even at the rate of four miles per hour, five times more lung service is thrown into action than during rest; which proves very conclusively that bodily activity possesses a marked influence in determining the degree of lung expansion, and that under such conditions regions of lung will be called into service which are never fully reached by air during bodily rest. This is in entire accord with what practically exists. Thus Darwin[1] says that the lungs in improved breeds of cattle, which naturally take very little exercise and are domiciled much of the time, "are found to be considerably reduced in size when compared with those possessed by animals having perfect liberty," and Waldenburg[2] states that the vital lung capacity is smallest in persons who lead sedentary lives, such as professional men, students, clerks, etc., and is greatest in those who follow active outdoor occupations, such as sailors, recruits, etc. Chassagne and Dally, in their joint work on the *Influence of Gymnastics on the Development of Man*, report that at the Military School of Gymnastics of Joinville-le-Pont, out of four hundred and one individuals subjected to gymnastic exercises for five months, three hundred and seven, or seventy-six per cent., showed an increase of an average of two and one-half centimetres in the mammary circumference of the thorax. According to Dr. Abel, seventy-five per cent. of those who practice gymnastics in Germany experience an increase in the measurements of the chest. There can be no doubt that the principal reason why consumption increases with the advent of civilization is that everything in civilized life tends to produce physical inertia in our bodies. Walking is substituted by riding in carriages and in cars; manual labor is in great part replaced by machinery; active out-door labor is supplemented by quiet indoor occupations; in fact, everything which tends to produce physical activity is exchanged for a life of ease and indolence. The American Indian, as has already been stated, is known to be comparatively free from the disease in his wild state, but as soon as he acquires the habits of and customs of civilized life he becomes its victim.

In converging the two lines of reasoning which have been thus far developed in this paper, it appears that the immunity from consumption which is established by residing in

[1] Animals and Plants, vol. ii., p. 361.

[2] Pneumatische Behandlung Respr u. Circul. Krankheiten, p 119.

a mountain climate, and by practising physical exercise, is chiefly brought about in the same manner, viz., by increasing the capacity of the chest. And from a practical point of view it is of some moment to know whether the former has more weight in bringing about such restoration than the latter—or, in other words, whether those who live in high altitudes continue to enjoy this exemption if they refrain from active physical exercise and take up a sedentary occupation in such regions. From recent inquiry into this subject we are inclined to believe, at least so far as the Rocky Mountains climate is concerned, that as soon as outdoor pursuits are exchanged for sedentary indoor occupations, consumption increases in frequency. It is, therefore, quite certain that physiological exercise plays a more important part in the problem of the prevention and cure of consumption than a residence in an elevated or mountain climate, however valuable the latter may be. We have, moreover, good reason for believing that the immunity which is established through physsical exercise is more permanent in character than that which is secured through residing in a mountain climate, for it is a common observation that consumptives flourish only in high altitudes so long as they remain; a protracted stay at the sea level is always regarded as perilous. Such consequences are in perfect harmony with what one would be led to apprehend from a knowledge of the physiological factors involved in the restoration of the patient. These factors are entirely local, and their influence does not extend very far beyond their immediate dominion. This objection does not hold good in regard to physical exercise. One thing may be said, however, in favor of mountain climate which is not true of physical exercise, viz., it produces its beneficial results without conscious effort on the part of the individual; therefore, when the remedy is viewed from a standpoint of ease and comfort, and not from one of permanence, the mountain climate is to be preferred.

In discussing the influence of mountain climate it must not be overlooked that, on account of its rarefaction, it increases the circulatory and cellular activity of the body, and in this way undoubtedly aids the process of nutrition; yet even this influence cannot be denied to physical exercise, although it is brought about in a more direct and positive manner. While increased chest capacity is, therefore, the great desideratum in preventing and treating consumption, we have the strongest evidence for believing that it is not so much a question of developing the base of the lungs as it is of expanding the apices. This is well shown by the fact that the civilized female, although she has on the whole much less chest capacity than the male, yet, owing to her increased costal expansion, which has been cultivated through the protracted influence of tight lacing, she is less liable to pulmonary consumption than the male.[1]

Pulmonary gymnastics.—Such, then, are the comparative effects of mountain climate and of physical exercise in the treatment of pulmonary consumption, and it now remains to be shown how the effects of the latter can be obtained without resorting to those of the former. Reference has already been made to the fact that muscular effort increases respiratory motion, and in taking up the question of pulmonary gymnastics it is not our purpose to discuss those exercises only which have a direct influence on the chest capacity, but also those which, through the body, have an indirect influence on the pulmonary organs. In all exercises it is very important that none should be carried to the extent of decided fatigue; and that, whenever possible, the body and head should be kept erect, the shoulders thrown back and the lungs thoroughly filled with each breath; that breathing should only take place through the nose; and that sufficient food is taken during the intervals.

Bodily exercise.—The power of walking is common to most people, and its influence on the lungs, as we have seen, is very marked. It is regarded of great service even by those who exclusively advocate the utility of high altitude treatment. Dr. Brehmer, of Görbersdorf, according to Schreiber, was the first to prescribe, for consumtives, walking up a gradual ascent. A semi-daily walk of half an hour or an hour, either on the level or on a slight upgrade, is of immense advantage to the invalid. Running, dancing, skipping rope (especially when the rope is swung backward), bowling, etc., are to be highly recommended. Whatever the mode of exercise may be, it must be performed under as little compulsion as possible. One reason why the above named exercises are so conducive to health consists in the fact that the excitement which they induce is so attractive that the consciousness of muscular effort is lost.

Among the many indoor exercises the following movements are very valuable. The arms being used as levers, are swung back-

[1] Female Dress as a Determining Factor in Pulmonary Consumption. Thomas J. Mays: *Medical News*, Jan. 7, 1888.

ward as far as possible on a level with the shoulders during each inspiration, and brought together in front on the same level during each expiration. Or the hands are brought together above the head while inspiring, and gradually brought down alongside the body while expiring. When a deep inspiration is taken is accordance with either plan and held until the arms are gradually moved forward or downward, or even longer, the process of chest expansion is materially enhanced. Another very effective exercise is to take a deep inspiration, and during expiration only the patient, in a loud voice, will count as long as possible. A male person with a good chest capacity can count up to sixty or seventy, while in a female with ordinary lungs this power is somewhat reduced. Practice of this sort will gradually develop the chest, and the increased ability to count is a measure of improvement going on within the thorax. Many of these movements may have their effects greatly enhanced by the use of dumb-bells, chest weights, etc., which are made especially for the purpose.

Compressed and rarefied air.—The breathing of compressed and rarefied air is attracting wide attention at the present time in connection with pulmonary consumption, and is another most useful method whereby the chest capacity can be markedly improved. Nearly four years ago Dr. Cohen, the honored President of our Society, advocated the substitution of compressed and rarefied air for a change of climate, in a paper which he read before the American Climatological Association. Here he says:

"In many cases fully as much good can be secured by this treatment as by change of climate, and in a few much more; though, in the vast majority of cases in which change of climate is advisible, it is but a poor substitute."

There can be no doubt that compressed and rarefied air is inadequate when used alone in many cases, but when combined with pulmonary gymnastics and other judicious treatment, we are not sure that the results obtained are inferior to those which are derived from climatic treatment. Recent experience has shown us that when consumptives, who had spent one or two winters on the Rocky mountains, or on the Pacific slope, without benefit, were subjected to the use of compressed and rarefied air in association with other pulmonary exercises, such as are above described, their improvement became marked and decided. On the whole, our experience with the air treatment, combined with pulmonary gymnastics, has been very favorable, and we think that this is in consonance with the observations of others. Thus the late Prof. Flint, in his work on "Phthisis," says (p. 406) "it does not appear, from the analysis of my cases, that changes of climate have in a marked degree a beneficial influence, as compared with the hygienic measures available at home."

We believe, however, that, as a rule, these measures are applied too infrequently to be of the greatest service; and therefore, insist that the pulmonary gymnastics are repeated every hour and a half during the day—the first thing in the morning and the last thing at night—and for from fifteen to twenty minutes at each time; and that the air inhalations be given at first twice, and in the course of two or three weeks gradually increased to four or five times a day, and even oftener. It is very true that this method of treatment involves more labor and perseverance on the part of the patient than is required in a high mountain climate; but then it is a question whether the patient is not more than compensated by the consciousness that a separation from friends is unnecessary, that the heavy expense, the dangers and discomforts incidental to travel are avoided, and, above all, that the improvement which may take place will be persistent and be practically unaffected by a change of residence.

Now, after reviewing the whole subject, we are driven to the conclusion that the line of immunity from consumption, which, in the early history of our country, was located at the Atlantic seaboard, and which has gradually receded westward with the tide of civilization, until at present it has reached the latitude of Colorado, will not stop in its course until it touches the shores of the Pacific; that the question of curing the disease does not depend on the purity or freshness of the air, or upon the number of bacilli which the atmosphere may contain, or upon the amount of oxygen which may be introduced into the body—for these are all secondary considerations; but it is simply a mechanical question—a question as to the best mode of expanding the lungs, and especially the apices of our round-shouldered and flat-chested patients, of removing the infiltrated products already existing, and of enhancing the constitutional resistance.

—On the 19th of February the corner-stone of a polyclinic was laid with appropriate ceremonies at Rome, Italy. Dr. Bacelli, professor at the medical clinic, delivered the address.

Society Reports.

MEDICAL SOCIETY OF THE COUNTY OF NEW YORK.

Stated Meeting, February 27, 1888.

The President, Laurence Johnson, M.D., in the chair.

Dr. Charles W. Allen read the scientific paper of the evening, on

Leprosy in the United States, and its Relation to the State.

The history of leprosy in the United States was reviewed. The questions as to its hereditary and contagious nature and the necessity for segregation were discussed. Some years since leprosy appeared in South Carolina, and it has also appeared in Louisiana, and in more recent years in Iowa, Minnesota, Michigan, Wisconsin and Illinois, to which places it had been brought by immigrants; it is also present on the Pacific slope, being brought there by the Chinese. Some cases have appeared in the States bordering on Mexico, where it had been brought by those coming from the South. A few natives have acquired leprosy while visiting foreign lands, and there have been reported five cases among natives who had never been abroad.

The author continued the histories of some cases at the Charity Hospital, which had been first reported by Dr. Piffard in 1883, and also gave the histories of two other cases which had not yet been reported. One of the latter was presented to the Society. In this instance some disfiguring effects of the disease upon the eyebrows and face had led him to institute surgical interference for cosmetic reasons. The wounds had healed readily. Dr. Allen thought we might safely estimate the total number of lepers in this country at one hundred and fifty, and not count twice cases reported by different observers. Owing to the size and geographical location of the United States, he thought we were likely to have more and more cases visiting our country.

Dr. Allen, in discussing the hereditary and contagious nature of leprosy, gave the opinions of those physicians who had resided in countries where leprosy was common, and also the conclusions reached by the committee appointed to investigate the subject by the Royal College of Physicians of England, as well as the opinion of the majority of the members of the Academy of Medicine, Paris, which was in opposition to the view of contagion. The majority looked upon the disease as hereditary, but there was a growing number of believers in the contagious nature of the disease, and this belief had led in different countries to the segregation of lepers. Individual instances were given to show the contagious nature of the affection. Those looking for proof of its infectious nature often failed to consider that the period of incubation might be many months or several years. In view of the action of the Philadelphia Board of Health we should seriously consider, he said, whether or not the disease was sufficiently contagious to justify State regulation. Syphilis and tuberculosis were contagious diseases, but only slightly so, and they had come to be very prevalent. He might be asked, why not institute isolation of patients affected with the latter diseases? Dr. Allen said he would favor isolation if it could be shown that thereby those diseases could be stamped out. If there were danger of leprosy spreading in our country by contagion, he thought we should segregate the patients afflicted with the disease.

Referring briefly to treatment, he thought that it was beneficial, and mentioned the value of chaulmugra oil.

Dr. H. G. Fox opened the discussion, and said that while he was not prepared to offer proof for his views, it was his opinion that leprosy was both contagious and transmissible by heredity. Although he believed it was contagious, it could be only very mildly so, and for that reason, and the further reason that our conditions were different from those of people in leprous countries, he did not think the State would be justified in shutting the patients up, and excluding them from association with their fellow-men unless the latter were similarly affected with themselves. He did not look upon leprosy as an incurable disease. One case in which he had effected a cure, principally by chaulmugra oil, was that of a patient from whom he had recently received a letter, stating that there had been no return of his former symptoms. But if patients were deprived of their liberty, all hope being taken away, and were allowed to associate with none but those similarly afflicted, no kind of treatment would be likely to prove of much benefit.

Dr. P. A. Morrow also believed that leprosy was both contagious and transmissible by heredity; that it was a germ disease, although we know very little regarding the method in which the germs entered the sys-

tem and the conditions necessary for the development of the disease. While he believed leprosy was contagious, it was evident that it was only very mildly so, and he did not think there was any necessity for State regulation in this country. The disease as it prevailed in the Sandwich Islands should not be taken as a basis of comparison for its probable advance in this country. The conditions were entirely different. It seemed to be the common impression that in Norway the decrease in the number of cases was due to segregation; but this was a mistake, for the lepers there were not rigorously isolated; they were allowed to go out and see their friends.

Dr. D. B. DELAVAN thought some of our physicians took too optimistic a view of the question under discussion: the relation of leprosy to the State. We should ask ourselves three questions: First, was leprosy at all communicable; second, was it all times equally contagious; third, what had been the result of segregation? While it may not have been shown to be very contagious, yet its history in Europe during the middle ages afforded a very instructive chapter. It started at one corner, and rapidly spread its ravages through the whole of Europe. Could we be assured that such an epidemic would not occur again? Wherever leprosy had prevailed segregation had been found desirable. Comparing the disease with syphilis and tuberculosis, Dr. Delavan said that if these latter could be stamped out by isolating a dozen or more patients, we certainly would be justfied in that course; if leprosy could be prevented from any further spread in this country by isolating the few cases now present, he thought the State would be justified in exercising such sanitary police regulation. Dr. Delavan also spoke of the beneficial results from the use of chaulmugra oil.

Dr. KOPLIK said the question had occurred to him, Might not opening up the lymph channels in a surgical operation for cosmetic effects, as was done by Dr. Allen, be followed by more rapid progress of the disease?

The following resolution, framed by the Georgia Medical Society, was adopted: Resolved, that we urge upon Congress that, in the cause of humanity, the import duty should be removed from all medicines, medical and surgical appliances, and from everything used in the treatment and diagnosis of disease.

—J. H. Walsh, the editor of the English sporting journal *Field*, died Feb. 12. He was a physician and practiced medicine for some years. He is the author of "British Rural Sports."

PHILADELPHIA COUNTY MEDICAL SOCIETY.

Stated Meeting, February 22, 1888.

DR. W. W. KEEN in the chair.

DR. THOMAS J. MAYS read a paper on

Apex Expansion versus Pure Air in Pulmonary Consumption.

In opening the discussion on Dr. May's paper[1] DR. W. W. KEEN said: These are very practical questions presented for discussion. Change of climate involves expense, separation from friends, interruption of employment. Can we obtain equal benefits by home gymnastics or change of employment? There is also a novel question raised as to purity of air. These points should be discussed.

DR. WILLIAM OSLER said: The last statement of the paper contains a very important truth. With imperfect expansion there is a liability to clogging of the interstitial circulation in the apices and accumulation of tissue *débris* which may afford a nidus for the development of the bacillus tuberculosis. The condition of activity of this interstitial circulation differs very much in different individuals. We know but little yet of the conditions which determine the development of tuberculosis. In part, at least, it is like the old parable of the seed and the sower: the nature of the soil will favor, retard, or prevent the growth. That the bacillus of tubercle will not grow in every soil is demonstrated by autopsies in large general hospitals. At Blockley, we will find in every hundred sections, say, fifteen or twenty cases with the usual lesions of phthisis; in fifteen or twenty there are no excavations, the lung not extensively tuberculous, but at the apices are small areas of induration, caseous nodules, and a few peripheral miliary nodules. The soil has not been congenial, and the development of the bacillus was restricted. Without bacillus, no tuberculosis; and that opinion is shared by ninety-nine out of every hundred clinicians of the day.

DR. EDWARD MARTIN said: While connected with the department of physical education at the University of Pennsylvania, I had an opportunity of studying the effect of exercise on chest development. Lads admitted with narrow lungs and supraclavicular depressions suffer, after moderate exertion, with embarrassment of pulmonary circulation. The right heart is congested, and there is evidently blocking of the blood cur-

[1] See page 295.

rent in the lungs. After six or eight months of carefully regulated exercise, there is a change in the local condition; no more obstruction is offered to the right side of the heart than elsewhere; the blood-vessels respond to the extra demand put upon them. With this free circulation goes an increase of chest girth, from an inch to two or two and a half inches in six months. Inspiratory exercises are nearly always given these young men, especially those with that shape of chest which we are taught predisposes to phthisis. Among these exercises is prescribed deep breathing, with or without movement of the arms. The arm is raised from the body to a right angle by the deltoid. After that the lifting is done by the serratus magnus, the most important external inspiratory muscle. As the arm is carried nearer to the head, the insertion and origin of the serratus are approximated and the muscle works at a disadvantage. For this reason expiration is practised as the arms are carried up, and inspiration as they are brought down. Exercise should be made vigorous enough to stimulate the heart action. Slow motions, as a rule, do not strengthen the heart muscle, but have a local effect, whereas the object in these cases is to make the circulation free and the air tubes pervious.

Dr. C. W. Dulles said: Dr. Mays has done good service by calling attention to the fact that the conditions to secure which consumptives are recommended to live at high altitudes can be replaced by simple measures. My observation, though limited, corresponds with that of Dr. Mays, and I think that all of us have been struck with the fact that there is no direct ratio between the percentage of cases of phthisis and the breathing of impure air. We often see a number of persons huddled into small, unventilated rooms, with filth and drink and all the factors of disease, and yet apparently in blooming health. In such cases the men, who are engaged in active employment, and the children, who run about in the streets, enjoy better health than the women, who have less active exercise and who bend over washtubs or sewing work.

Dr. George E. Shoemaker said: I heartily agree with Dr. Mays that apex expansion is an important part of the treatment of incipient lung disease. A very important point is raised as to the action of rarefied air in expanding the apices. In localities that are warm, moist, and low—like Florida, for example—there is no such effect, and almost the sole benefit, as far as the climate is concerned, is from the patient's ability to be outside all the time. Now would it not be better to send more of our patients to a climate where direct good is gained by the more thorough ventilation of the lungs, reserving for Florida the very weak and those liable to excessive hemorrhage or to heart failure? In regard to impure air, we must remember that many of those persons who enjoy good health in spite of their home surroundings, live out of door most of the time, the children, in particular, living upon the doorstep or in the street, except in stormy weather. In the same way at mountain and seaside resorts, the small and uncomfortable rooms drive visitors out into the air; and whether or not ozonized or rarefied, it is pure, out-of-door air.

Dr. Mays said, in closing the discussion: It is rather unfortunate that Dr. Osler did not confine himself to the topic of the paper and discuss the main points of the subject in his usual able manner. I purposely avoided all except an incidental reference to the bacillus; but I must now say that I cannot accept the dictum, "no bacillus, no tuberculosis." It seems very strange that if the bacilli need a soil in which to develop they should be able to penetrate into that portion of the lung which is hardly ever expanded in phthisical patients. Why, if you take the two sexes and put them side by side in the same employment, do the men become diseased in greater proportion than the women? Why this fondness of the bacilli for one sex? I must also dispute the point that ninety-nine of every hundred clinicians accept this dogma. Though born in Germany, the doctrine is already losing ground among the Germans. I wish, in conclusion, to make a statement which I should have embodied in the paper, that, according to the latest researches, the apices expand more in the recumbent than in the erect position; therefore, a person inhales more air during sleep than in waking hours.

—Admiral Hutton Versturme, who retired from the British navy about a year ago, and lived near Falmouth, Eng., recently committed suicide. He was found in the drawing-room in front of the fireplace suffering great agony, with his wife also in the room insensible. A doctor found that he had thrust into his stomach a thin brass-handled poker, red hot, inflicting three severe wounds. He died the next day. He spoke several times, once saying, "It was because of the whiskey I did it." He was much distressed through not coming into a fortune that he had expected on the death of a relative.

Reports of Clinics.

HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA.

MEDICAL CLINIC—PROF. PEPPER.

Circumscribed Pleuritic, Simulating a Pericardial Effusion.

William B., aged 68. This old man was admitted to the wards about six weeks ago. The prominent symptoms from which he was suffering at that time was an urgent dyspnœa, and, what was remarkable in the case, there was no discoverable cause sufficient to account for it. The heart, for a man of his age, was quite normal; no organic lesion was present, and the pulse was regular and fairly strong. The kidneys were searched for some evidence of Bright's disease, which would offer an obstructed circulation as a partial explanation of the dyspnœa, but without success. Repeated examinations of the urine proved entirely negative. There was a slight cough present, but the lungs on being examined, were found to be quite healthy with this exception: at the right base posteriorly a small patch could be outlined, over which numerous small râles were heard. Some infiltration was present here, but no solidification. Bacilli were looked for in the sputa, but none were found. The patient was rather anæmic, and there was some slight febrile disturbance. This was all. Certainly there was nothing in these insignificant data to explain the markedly oppressed respiration. The man was placed upon a tentative plan of treatment and kept under close observation. As time passed, the area of infiltration at the base of the right lung increased in extent and spread upwards as high as the lower angle of the scapula. At the same time, the dyspnœa became even more harassing so that the patient was almost gasping for breath. As these conditions gradually acquired greater prominence, it was noticed that the area of cardiac dullness was extending; that there was a palpably increased fullness of the precordia, and that the heart-sounds were receding. A week ago the cardiac dulness extended, vertically, from the second to the sixth rib; horizontally, from the right border of the sternum to a point an inch outside the nipple line. The heart's impulse became almost imperceptible and its sounds could only be distinguished at the base. With all this, gentlemen, I venture to recall your attention to the fact that, on admission, the patient presented no evidence of any organic lesion of the heart.

Now what was the morbid condition here that we were called upon to treat? There was undoubtedly a large quantity of new material in the thoracic cavity, but was it solid or fluid, and what was the connection between it and the pulmonary lesion on the right side? The possibility of neoplasm, malignant or benign, was first considered. The evidence furnished by physical examination, however, was all against the adoption of such a view. Neither lung was displaced to any extent, nor was there marked dulness over them at any point; the position of the heart was not materially altered, its sounds and impulse being rendered indistinct by this new growth or effusion gradually surrounding it rather than pushing it aside. A solid body, moreover, would not have exhibited such rapid increase as was obtained here.

We had, therefore, to deal with a fluid, an effusion, and, in the entire absence of anything pointing to the existence of pus, a serous effusion. To verify this conclusion the needle of a hypodermic syringe was inserted just outside of the apex line of the heart and a drachm of serous fluid drawn off. Having in this way satisfactorily disposed of this first question, a second now presented itself for solution. Was this a collection of fluid within the pericardial sac or was it a circumscribed effusion into the left pleural cavity? It will be remembered that at the time of the patient's admission, the difficulty of breathing was most urgent, and yet careful examination of the heart at that time failed to reveal the presence of an abnormal amount of fluid within its enveloping membrane. The cause of the dyspnœa, therefore, was exo-cardial, and while this symptom steadily increased in severity, it was not until the man had been under close observation for some days, that the bulging of the intercostal spaces was noted, and the impulse and sounds of the heart began to grow fainter. From a careful review of this array of facts, we are led to believe that the effusion is pleuritic in origin, and that it is limited by old adhesions to the inner portion of the pleural cavity extending forwards to the anterior border of the lung and overlapping the heart. It is probably dependent upon a sub-acute inflammatory process, the exciting cause of which we do not know.

A week ago the needle of an aspirator was introduced into this distended cavity and thirty-six ounces of a clear serous fluid drawn off, the resulting relief to the patient being, as you may imagine, very great. My examination to-day shows that there is some re-accumulation of the serum, and I think it

likely that the tapping will again become necessary.

Before dismissing this case I wish to say one word with regard to exploratory punctures of the pericardial sac. When it is desirable that one of these shall be made, the point always selected by me for the insertion of the needle is the normal site of the apex beat of the heart. I puncture here because it is at this point that there is the least danger of wounding that organ. If any pericardial effusion occurs, even though it be slight, the apex of the heart being its most freely movable portion, is early displaced and pushed up of harm's way.

General Tuberculosis.

Harry S., 4 years old, youngest of eight children, the eldest of whom died a year or two ago of phthisis. The mother a healthy woman, but the father syphilitic. The child began ailing early in December last. The bowels became irregular in their action, constipation alternating with diarrhœa; colic was of frequent occurrence, the appetite became capricious, the stomach irritable, and vomiting easily induced. Irregular febrile disturbance, restlessness, and broken sleep became prominent symptoms, and the child underwent rapid emaciation. Examination reveals the following conditions: At the upper part of the abdomen, just below the border of the diaphragm, we find a network of dilated veins, these indicating the existence of some obstruction to the intra-abdominal circulation. There is no fluid of consequence in the belly, but on palpation it is found to have a doughy, inelastic feel, and is somewhat resistant to pressure. Passing upwards to the contents of the thoracic cavity, we find the entire right lung a mass of infiltration, tubercular deposits being disseminated throughout its whole structure, with commencing softening under the clavicle. There is, in addition, internal strabismus of the left eye which is strongly suggestive of tuberculosis of the cerebrum or meningeal membranes. To sum up, therefore, we have first extensive tuberculization of the peritoneum and intestines; next, a widely disseminated tuberculosis of the right lung; and, finally, a well-grounded belief as to the existence of intracranial tubercular deposits. Such general tuberculosis as this is rare in so young a child, and is particularly remarkable in this case because the first symtoms of disease were observed scarcely more than two months ago.

The treatment of such a case can, of course, be simply palliative. The most sanguine of therapeutists could not hope to effect a favorable issue. Elevation of temperature will be kept within bounds by moderate doses of antipyrine, and pain and diarrhœa controlled by opium. As other symptoms arise or occasion distress they will receive attention, but these are at present the leading indications.

Foreign Correspondence.

Letter from Canton, China.

It may interest the readers of the Reporter to hear and learn something of medical work in the far East, and of what the Canton Medical Missionary Hospital is doing for the Chinese. Fifty-two years ago this hospital began its work of benevolence in this great city which has a population of a million and a half. At first under the care of Dr. Peter Parker and others, it has for the past thirty-one years been nearly all the time under the care of Dr. J. G. Kerr, by whose skillful management and untiring devotion it has risen to one of the largest (if not the largest) hospital in the East, and with a reputation among the Chinese reaching all over this vast empire. It is impossible to get an adequate idea of the large amount of work done and good accomplished at this hospital year after year.

There are two departments, one for men and one for women, and at present two hundred and fifty in-patients can be accommodated. During some of the summer months every ward is crowded to its utmost capacity. While many cases coming under the class of general diseases are admitted, yet the work so far as in-patients are concerned is largely of a surgical nature. These include all affections that fall to the surgeon's lot at home, specially prominent among which are: urinary calculus; tumors, both malignant and non-malignant, including all varieties of cancer; caries and necrosis; cataract, etc. Two wards are devoted to cases of urinary calculus, and during most of the time there are from ten to fifteen of these patients present, either under preparatory treatment or already operated upon. During the past three years (Jan. 1, 1885, to Jan. 1, 1888) there were one hundred and twenty operations of lithotomy, and thirty-three lithotrity operations performed; the age of the patients ranging anywhere from one year to seventy-five years. Dr. Kerr has performed hundreds of these operations, and with reference to numbers and good results in this disease he probably stands as one of the first surgeons in the world.

Two days of the week are devoted to seeing out-patients who come in great numbers, as will be seen by the summary given below. Well trained native assistants do much of the routine work, and a medical class of young men receive regular instruction. Calls are frequently made to see patients who are unable to come to the hospital, and many of these are obstetrical cases.

A summary of the work for 1886 is as follows:

Number of out-patients,	13,000.
" " in-patients,	1,300.
" " operations performed,	2,200.

It is impossible at present to go into details, or report any of the rare and interesting cases that are constantly occurring in our practice.

Dr. Kerr is at present assisted by Miss Mary W. Niles, M.D., and the writer of this article; but until within a few years he has carried on this great work alone, living in this tropical climate, in a heathen city, hidden from the world and society, devoting his life to the relief of his fellow-men and the service of the Great Physician, for the advancement of whose cause he labors.

The influence of this hospital for good is far-reaching and untold. During the year 1885 there were patients from every province in the Chinese empire, except one, and from Manchuria beyond the northern border. Native students have gone forth to hold important positions. Instruction in the Christian religion is always a prominent feature in connection with the work. Numerous medical works, translated by Dr. Kerr, are known and in use wherever Western medical science is taught to the Chinese.

May the day be soon forthcoming when the medical profession in general will carefully inquire into the subject of medical missions learn what they are doing and of the great work yet to be accomplished by them.

Yours truly,

JOHN M. SWAN, M.D.

Canton Hospital, Canton, China,
January 14, 1888.

—The *Boston Med. and Surg. Journal*, Feb. 16, 1888, states that it appears from the annual report of the Harvard Medical School, 1886–1887, that not one-half of those who take the fourth year course apply for the fourth year degree. During the past four years 35 per cent. of the candidates for the fourth year degree have been rejected. The number at present in the fourth year class is stated to be 10.

PERISCOPE.

Microbes and Expired Air.

Strauss and Dubreuih (*Concours Médical*, No. 50, p. 601, 1887) have recently made extensive experiments, and working in a different manner have confirmed early results of Tyndall's, showing expired air to be entirely free from germs. Their method was to pass the air through tubes containing sterilized nutrient solutions, using about one hundred and fifty to two hundred liters of air for each tube. Almost without exception the tubes remained sterile, and the number that did not, could be accounted for by errors of manipulation. These experiments show that the lungs act as filters to the inspired air, an action easily explained by the conditions under which air circulates in the lungs, through narrow channels lined with moist epithelium. Grancher, Charrin and Karth, have already shown the air expired by phthisical patients to be free from the pathogenic bacillus. There is no contradiction between these facts and those long ago observed by Pasteur, and confirmed by many since then, showing the abundance of germs in hospital wards, barracks and other crowded apartments. It is not by the respiration that crowds charge the air with microbes. This is done by means of clothing, by the dust set in motion by their movements, and by dried and pulverized expectoration.

Quarantining School-Children after having Contagious Diseases.

The Section of Hygiene of the Academy of Medicine of Paris has recently reported to the Academy some suggestions as to the duration of quarantine to be imposed on school-children who have suffered with a contagious disease, among which whooping-cough is now classed in addition to the diseases named in the report of 1881. The present report was made to the section on hygiene by M. Ollivier. From the *Bulletin de l' Académie de Médecine*, Jan. 24, 1888, we quote the following suggestions:

1. Pupils attacked with chicken-pox, small-pox, scarlet-fever, measles, mumps, diphtheria, or whooping-cough shall be strictly isolated.

2. The duration of this isolation shall be reckoned from the onset of the disease—the first day of invasion; it will last forty days for small-pox, scarlet-fever and diphtheria; twenty-five days for chicken-pox, measles, and mumps. As the duration of whooping-cough is extremely variable, a return to school

should not be authorized until thirty days have elapsed after complete disappearance of the characteristic fits of coughing.

3. Isolation shall cease only when the convalescent shall have taken two or three soap-baths, and have been submitted to an equal number of general frictions, even of the hairy parts of the skin.

4. The clothing which the pupil had at the time when he was taken sick should be subjected to the action of steam under pressure or to the action of sulphur fumes, and then well cleaned.

5. The room which has been occupied by the patient should be well aired. Its walls and furniture shall be thoroughly disinfected; the bedding shall be subjected to the action of steam under pressure; and finally, the mattress shall be taken apart and submitted to the same treatment.

6. In any case the pupil, who shall have been attacked outside of a public school with one of the contagious diseases enumerated in this report, shall be received again only when provided with a certificate from the physician stating the nature of the disease and the time which has since elapsed, and attesting that the pupil has fulfilled the above requirements. Finally, the reception of the pupil shall always be subject to the results of an examination by the physician to the school.

Bacteriological Water-Test.

At the meeting of the Society of Medical Officers of Health (*Brit. Med. Journal*, Jan. 7, 1888), Mr. Gustav Bischof read a paper on extension of time of culture in Dr. R. Koch's bacteriological water-test by partial sterilization, with special reference to the metropolitan water supply. The following conclusions were drawn: 1. No bacteriological water-test can satisfy the demands of hygiene unless it is qualitative, distinguishing between harmless and pathogenic microphytes. No such test is at present known. 2. Merely numerical results, without such distinction, are entirely unintelligible, unless the time and other conditions of culture of each test is specified. 3. A small portion only of the colonies capable of growing in gelatine peptone is indicated by three days' culture. 4. The ratio of colonies thus indicated by three days' culture to that of the total present appears to differ so widely in different samples that the numbers of colonies obtained from them cannot be compared with each other. 5. Instead of any such comparison, the changes taking place from time to time should be followed up in each sample separately. 6. Extension of culture beyond three days increases the reliability of the results. How far this holds good, and how far culture should be extended, we have at present not sufficient evidence to show. 7. The usefulness of results is probably still further increased by combination of extension of culture with storage in sterilized flasks for a certain time. 8. As regards the control of the working of sand filtration at waterworks, any bacteriological test, to be of practical utility, should be repeated at intervals certainly not exceeding a fortnight. 9. It is desirable for the purpose of such control to test the water entering and leaving each filter.

Aprosexia.

"Aprosexia," a word clear to the Greeks, is the name of a new disease discovered by Guye, of Amsterdam. He understands by it a specific disturbance of the functions of the brain, appearing in the form of an inability to direct the attention to a particular subject. The well-known nasal reflex, the scapegoat of many who cannot explain a phenomenon, is brought forward again in this disease: aprosexia is a condition of exhaustion in consequence of difficult breathing in nasal diseases; certain cases of "overwork" belong to it.

As put by the critic in the *Berliner klin. Wochenschrift*, Dec. 5, 1887: "if Guye is correct, the future 'school-doctor' will have to examine the noses of scholars on the rear benches most thoroughly."

Dysentery with Gangrene of the Left Foot.

At a meeting of the Royal Academy of Medicine in Ireland, December 2, 1887, (*Lancet*, January 28, 1888), Dr. W. G. Smith reported the case of a young woman, 19 years old, who was admitted into the hospital September 2, 1887, suffering from intractable diarrhœa of a week's duration. Her illness had commenced suddenly, and followed the eating of some stale fish. When admitted she was in a state of extreme prostration; pulse 120, temperature 99.5°; frequent dysenteric stools. No treatment proved of any avail, and she died after a week's stay in hospital. Two or three days after admission her left leg was observed to be very cold. It was also painful, especially in the popliteal space, and purple patches appeared on the foot. These latter increased and deepened. Dry gangrene attacked the toes, and spread over the sole of the foot. At the autopsy, characteristic signs of dysentery were found, but no vascular obstruction to account for the gangrene.

Acute intestinal Obstruction; Laparotomy; Recovery.

The *Lancet*, January 7, 1888, reports the case of a man, 45 years old, a laborer, who was admitted on April 30, 1887, to St. Bartholomew's Hospital, under the care of Mr. Morrant Baker. The patient gave a history of double, reducible inguinal herniæ, of many years duration. A truss had been worn during the previous eight years. He had also a small reducible umbilical hernia. The patient had been quite well up to the morning of April 25 (five days before admission), when, after working about half an hour, he was suddenly seized with severe abdominal pain, which was referred to the umbilicus, and thence downwards to the right side of the pubes. The pain was of a dragging character, and thinking that it might be due to the hernia on that side not being quite all reduced, he lay on his back and re-adjusted his truss, but without relief. The pain continued all that day and the next, but he still remained at work, and vomited a little on both days. On April 27, the pain was worse, and the vomiting more frequent. On the 28th and 29th the pain and vomiting had increased. On the day of admission (30th) the patient was much worse and very weak, the pain being intense, and he had vomited at least twenty times in the twenty-four hours.

On admission, he was much collapsed, with all the symptoms of acute intestinal obstruction. The abdomen was somewhat distended, and acute pain was complained of, extending from the umbilicus to the right side of the pubes. The tongue was thickly furred and dry; the pulse 84, and weak; the temperature 99.6° F. There was frequent vomiting of a foul-smelling, green liquid. The patient did not remember having passed flatus after the onset of the pain.

After chloroforming him, the herniæ were carefully examined, and found to be easily and completely reducible. The abdomen was therefore opened, and on the right side was found a sense of resistence as though "the coils of intestine were tethered in some abnormal way." In endeavoring to find the cause for this, and in making some traction on the tense bowel, the coil suddenly came into view, and presented to the eye at once an intensely inflamed spot of about the size of a florin with dusky centre. The inflamed surface was rough, as if it had been firmly adherent and tightly gripped. The piece of intestine was immediately returned and the abdominal wound stitched up in the usual way. The patient was immediately relieved by the operation, and convalesced rapidly.

The author in commenting on this case, expresses the opinion that it was one of strangulated obturator hernia. This, he thinks, is indicated by the fact that other herniæ existed. At all events, he regards it as a case of intestinal obstruction which would have proved fatal without operation.

Mental Disorder Caused by Jaborandi.

Dr. Wauzh, of Liège, who has great belief in the efficacy of jaborandi as a stimulant of the mammary functions, mentions a case which has recently occurred in his practice, showing that inconveniences may occasionally arise from the administration of this drug. He prescribed ten drops of the fluid extract every four hours for a patient whose milk had ceased for a fortnight, with satisfactory results, the secretion being re-established. After a time, however, the patient began to suffer from extreme nervous excitement, accompanied by a fixed idea that she should murder all her family with a hatchet. On the jaborandi being stopped, these alarming symptoms disappeared, and together with them the activity of the mammary glands.—*Lancet*, December 24, 1887.

Primary Inflammation of the Internal Ear.

G. Gradenigo contributes to the *Arch. für Orenheilkunde*, xxvi, S. 46, the result of an anatomico-pathological investigation upon the organs of hearing of a deaf-mute girl, fifteen years old, who died of pulmonary phthisis. Anatomical information with reference to the primary affection of the ear was wanting. The autopsy disclosed bilateral complete destruction of the membranous labyrinth, and of the elements of both windows of the labyrinth; and new formation of fibrous and bony tissue, which appeared especially pronounced on the left side, where there was, in addition, a chronic suppurative inflammation of the middle ear. The newly-formed bone tissue is derived partly from the endostium of the labyrinth—periosteal bone, which is present only in the vestibule and gyrus basilaris cochleæ; and partly from direct proliferation of newly-formed fibrous tisssue — especially in the cochlea bordering on the modiolus. There was no trace of the semicircular canals; the vestibule was decidedly narrowed; and in the cochlea the new-formed bony tissue diminished as the apex was approached.—*Centralblatt f. d. med. Wissensch.*, Dec. 10, 1887.

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THE ABUSE OF ALCOHOLIC BEVERAGES.

Among the many interesting and important subjects discussed at the recent Hygienic Congress in Vienna, none was more interesting or more important than that of the abuse of alcohol as a beverage, and the means for correcting this abuse. The discussion which took place at the Congress has been followed by an equally interesting one by the members of the German Society of Public Hygiene, which is reported in the *Deutsche Medizinal-Zeitung*, Feb. 6, 1887, and in which a number of men who had attended the Congress took part. At this meeting, SPINOLA made an address, in which he described the great increase of liquor-drinking in civilized countries during the last few decades, and attributed this increase largely to the cheapness of strong alcoholic beverages, and the multiplication of what are called in this country drinking saloons. To this statement of the causes of the increase in the consumption of alcoholic liquors, he added some suggestions in regard to the best way to correct the abuse, which may well be reproduced.

These suggestions include action by governments and action by citizens banded together in voluntary organizations. The duty of governments consists in regulating the liquor-traffic, by imposing taxes, so arranged that they will make strong alcoholic beverages comparatively costly, and mild alcoholic beverages comparatively cheap. Further, governments should restrict the number of places in which alcoholic beverages are sold; should subject them to close supervision, and regulate the quality of liquors sold, as well as the methods of dispensing them. It was further suggested that governments should exercise a strict supervision over persons addicted to the abuse of alcoholic beverages, confining them when they become public nuisances, or when they neglect to support themselves or those naturally dependent upon them.

The duty of citizens, as citizens, was defined by Spinola as consisting in supporting the government in its efforts to lessen the evil of intemperance, and in organizing to promote temperance—or total abstinence, if that be preferred—and in furnishing the poor with sound teaching, good food, non-intoxicating beverages, and rational forms of amusement.

To the support of these opinions, which were those of the Vienna Congress, as well as his own, Spinola brings an array of statistics which is of the greatest value. It seems clear from them that the abuse of alcoholic beverages is actually the great evil which most independent observers believe it to be, and that the methods he suggests are well calculated to correct it. We have no space in which to reproduce the details of his statistics; but we think it worth while to call attention to the plan which has worked so well in Norway and Sweden, where the so-called Gothenburg system is in force. The essential features of this system are that a responsible society purchases the right to sell liquors, and that the profits are used to pay interest upon the capital of the Society, and the excess above this interest is devoted to public and charitable uses. A detail of the system, which is not without influence in

diminishing the abuse of alcoholic beverages, consists in the fact that the keepers of drinking-places may not sell alcoholic beverages for their individual account; but may so sell non-alcoholic beverages and articles of food. This gives them a direct interest in diminishing the use of alcohol, and encouraging that of articles of food and drink which contain no alcohol. As a result of these measures, and of careful supervision by the government, the average consumption of strong drink in Norway, which was fifty-four liters *per capita* annually fifty years ago, is now only eight liters, or about one-seventh of the former figure.

The facts stated above are of great interest to the citizens of this country, in connection with the efforts now being made to correct the abuse of alcoholic beverages which afflicts the United States. We have, from time to time, published information in regard to the operation of laws for the regulation of the liquor traffic, indicating our sympathy with the endeavor to lessen as much as possible the dreadful effects which it entails upon our own land, as well as upon all civilized lands. And we wish to do all in our power to secure the co-operation of the medical men of America in the labors of benevolent men of all callings to correct, as far as possible, the curse of intemperance. No class in the community knows better than physicians do the bitter effects of intemperance; and none can more appropriately discuss these effects, or suggest methods for preventing them.

MEDICAL EDUCATION IN THE UNITED STATES.

In the *Report of Proceedings of the Illinois State Board of Health*, at its annual meeting, January 12–13, 1888, there is a very interesting review of the condition of medical education in this country. The data gathered by the Illinois Board of Health indicate a continuing improvement in the methods and an elevation of the standard of medical education in the United States. The report states that there are now one hundred and fourteen medical schools which exact an educational preparation of intending matriculates, as against forty-five formerly; forty-three schools now require attendance upon three or more courses of lectures as against twenty-two formerly; and fifty-seven provide for a three or four years' graded course. The average length of each course of lectures has increased, and sixty-three schools have terms of six months or more. One of the effects of a higher standard of medical education is seen in a decreasing proportion of graduates to matriculates.

These facts may serve to encourage those who desire and labor for a high standard of medical education in America. An improvement in this respect is much needed. We are not of those who think that one standard can be made for all the schools of this country; because we think that the varying conditions of wealth and population make it impossible to require of those who practice in different portions of this wide land the same degree of education. There are many sections of the United States which would have no physician at all, if no one could be a physician except at a cost of time and money which but few can spare. For this reason we see a distinct field of usefulness for medical schools which exact attendance on only two courses of lectures. But we think that such schools should not pretend to exact more, and that they should use their "liberty as not abusing it;" and that they should make the very most they can of the time during which their students are under their control. The course of time and the material development of our country may be trusted, we believe, to bring about an improvement all along the line of medical education; but no effort should be spared to raise the standard everywhere, so that it should nowhere be despicable. It is not enough to show that excellent practitioners come—as they do—every year from schools with short terms of study; for there can be no doubt that these same excellent practitioners would do their work better if they studied a longer time. So it is a good thing to encourage and stimulate all the medical schools of America to set before them a high ideal, to which some can and will come nearer than

others, but toward which all should strive to approach as much as the conditions peculiar to each will permit.

LIPANINE—A SUBSTITUTE FOR COD-LIVER OIL.

In the *Therapeutische Monatshefte*, February, 1888, Dr. J. von Mering has an interesting paper, in which he discusses the relative merits of brown and white cod-liver oil, and expresses the opinion that the generally admitted superiority of the former is due to the fact that it contains a larger percentage of oleic acid than the latter does. This opinion has led him to make an artificial compound of olive oil and oleic acid—six parts of the former to one hundred of the latter—which is less objectionable than brown cod-liver oil, on the score of taste, and which seems to possess many of the nourishing properties of the latter. This compound is now introduced in Germany under the name of "Lipanine." According to von Mering, it is not disagreeable in taste or smell, and it is very easily digested. It is easily emulsified in a weak alkaline solution, corresponding to the alkalinity of the contents of the bowels, and hence it is easily absorbed by the lacteals of the intestines. As a result of this fact it is possible to administer it in large doses and for a long time without arousing disgust or causing indigestion. Von Mering has given lipanine to more than forty patients in six months, thirty of them being children. All took the compound well, and it never caused nausea, vomiting, indigestion, or diarrhœa. The children to whom it was given were scrofulous or rachitic; and of the adults, four had phthisis and ten had diabetes. In all these cases the patients gained in weight and their general condition improved. The dose administered was from one to four teaspoonfuls daily to children, and from two to six teaspoonfuls daily to adults.

The results of the administration of lipanine, announced by von Mering, suggest the advisability of testing this remedy in this country. It is so easy to make and so convenient to administer that enterprising pharmacists may be expected to place it soon before the medical profession of America. A palatable substitute for cod-liver oil is a thing much to be desired, and we hope this one may prove as valuable as its inventor believes it to be.

NERVE SUTURE AND NERVE STRETCHING.

A great deal has been done in the last few years—especially in Europe—in the direction of uniting the separated ends of divided nerves, and a number of methods have been devised by which the ends might be brought together when the gap between them was considerable. Various processes of grafting, by flaps and by the interposition of materials intended to serve as a sort of scaffolding for the budding prolongations of the cut ends have been devised, and have been employed with considerable success. But only recently Prof. Max Schüller, of Berlin, has put into practice a plan which promises better results than any which we have yet seen proposed. This plan consists in making use of the well-known elasticity of the nerves, by laying bare a portion of the central, and, if convenient, of the peripheral end, and then stretching them over the gap until they meet and may be directly united by sutures of catgut. In the *Wiener Med. Presse*, January 29, 1888, Schüller reports a most interesting case in which he employed this method, with signal success. The patient was a worker in a chemical establishment, who in November, 1884, wounded himself in the palm of the right hand with a piece of glass broken from a bottle which he was corking. The symptoms pointed to a division of the median nerve; and when Schüller operated in May, 1885, soon after first seeing the patient, this was found to have occurred, and also, that a piece of glass was embedded in the imperfect scar at the seat of the wound. The operation consisted in laying bare the nerve from the lower part of the forearm to the middle of the palm, excising the scar tissue, removing the fragment of glass, and uniting the severed parts and branches of the nerve with fine catgut sutures. After this the wound in the skin was closed and dressed antiseptically, and

the hand and arm were fixed upon a suitably curved dorsal splint.

The issue of this operation was most satisfactory, and furnishes strong evidence of the value of the method. In carrying it out it would be well to follow the example of Schüller in sparing the nerve-fibrils as much as possible when applying the sutures, and in passing these very carefully, with delicate curved needles, such as are used in stitching a wounded bowel, through the sheaths of the nerve only. So far as the extent to which a nerve may be safely stretched is concerned, Schüller believes, from the result of his experience, and of certain experiments which he has made, that a gap of an inch and a half in the main nerves of the extremities can be bridged in this way. Violent and too extensive stretching would not commend itself to any prudent surgeon; but, within the bounds suggested by Schüller, we think that nerve stretching will prove a very valuable preliminary to nerve suture.

PASTEUR AND PESTILENCE.

It is reported from London that the inhuman proposition made some time ago by Pasteur, to send to Australia the germs of fowl-cholera, to be scattered among the rabbits, which prove such a nuisance there, is being carried out. It is stated under date of Feb. 27, that three agents of Pasteur have sailed for New South Wales, with material to spread the fowl-cholera among the rabbits, in the hope of exterminating them. This incident, of heartless and cold-blooded cruelty, may perhaps open the eyes of some persons who have accepted the posing of Pasteur, and the claims of his admiring son-in-law that he is a great humanitarian. If those who live near him are to believed, there never was a man who more carefully calculated the commercial value of his scientific work, and this last act shows that he is a man, who for the hope of the large reward which has been offered for the extermination of rabbits in Australia, will deliberately sow among them the seeds of a slow and torturing disease. What is to be thought of the Government of Australia if it permits this plan to be carried out, we do not venture to say, since the plan has not reached the stage of execution yet. But we hope the people of Australia will find a way to prevent the carrying out of this mercenary and cruel scheme. Humanity should prompt them to this, not to mention the possibilities of danger to man himself which are involved in spreading a deadly disease among animals.

FORCIBLE FEEDING OF THE INSANE.

In the *Wiener Med. Presse*, February 5, 1888, Dr. Julius Rader, physician to the Austrian Insane Asylum at Ybbs, describes the case of a woman affected with delusional insanity, who indulged in periodical fastings from 1881 to 1887. The longest fast was for twenty-one days. The study of this case leads Rader to deprecate the practice of forcing food upon insane persons who have made up their minds to eat nothing. This practice he holds—and we believe with reason—to be not only useless but dangerous. That it is useless is shown by the fact that persons, both sane and insane, have been known to go without food for long periods of time without material disadvantage, and that the insane seem to bear fasting better than the sane. That it is dangerous is evidenced by the fact that not a few cases are known in which serious injury has been done to insane persons by the violence necessary to force food into their stomachs, which they can, and do sometimes get rid of immediately by vomiting. In addition to this, in a number of cases one effect of this vomiting has been to lead to aspiration of vomited matter into the lungs, and a consequent pneumonia.

Bearing these facts in mind, we can approve Rader's suggestion that more is to be feared than is to be hoped for from forced feeding of the insane, and that it would be well for those who have the care of these unfortunates to dismiss their alarm at an obstinate refusal to take food for many days, and to relinquish the notion that, under such circumstances it is desirable to bind the patient, introduce a stomach tube, and force food into an unwilling and intolerant guest.

Book Reviews.

[Any book reviewed in these columns may be obtained, upon receipt of price, from the office of the Reporter.]

CONTRIBUTIONS TO THE STUDY OF THE HEART AND LUNGS. By James R. Leaming, M.D., Emeritus Professor of Diseases of the Chest and Physical Diagnosis in the New York Polyclinic, etc. 8vo, pp. 300. New York: E. B. Treat, 1887. Price, $2.75.

This handsomely printed book contains a series of papers on diseases of the heart and lungs, read and published by the author between 1865 and 1875, and discussions of the therapeutic value of chloride of ammonium, mercury and thuja occidentalis. Most of these papers have been before the profession long enough to receive criticism from those who dissented from any of the views expressed, and the author has presented them again in the shape which his mature reflection approves, after giving careful consideration to the opinions which have been expressed in regard to them.

The result is a book which contains much valuable information in regard to various physiological conditions of the heart and lungs, and which is calculated to be useful, as it certainly is interesting.

THE INTESTINAL DISEASES OF CHILDHOOD. By A. Jacobi, M.D., President of the New York Academy of Medicine, etc. 5½ x 7 inches, pp. xvi, 301. Detroit: Geo. S. Davis, 1887. Price, 25 cents.

This book is the number for September, 1887, of what the publisher calls "The Physicians' Leisure Library." The numbers are supposed to be issued monthly, at a subscription price of $2.50 a year. Some of these books are excellent; but some of them bear manifest marks of being made to order. This one is an example of what we mean. It is divided into chapters or sections, some of which are ridiculously small: one containing exactly four lines. Of course what Dr. Jacobi says about the diseases of children deserves respectful attention; but we regret that he has in this instance consented to make a book which few lovers of books will think worthy of his reputation. The publisher's part of the work is marked by evidences of carelessness and a lack of a good book-instinct, which are abundantly illustrated in the table of contents.

TRANSACTIONS OF THE NEW YORK STATE MEDICAL ASSOCIATION FOR THE YEAR 1886. Vol. iii. Edited for the Association by Alfred Ludlow Carroll, M.D. 8vo, pp. viii, 601. Concord, N. H.: Republican Press Association, 1887.

This is an exceedingly handsome volume, which does equal credit to the scientific status of the State Medical Association of New York, and the wisdom and skill of the Committee on Publications and of its Editor. The papers cover a wide range of medical and surgical subjects, and the book contains memoirs and handsome portraits of Drs. Austin Flint, Frank H. Hamilton and John P. Gray. Where there is so much of value and interest it would be impossible to select a few papers for notice without being invidious; and we must content ourselves with expressing our admiration of the whole in this general and unstinted way.

THE BONES OF THE LEG CONSIDERED AS ONE APPARATUS. By Thomas Dwight, M.D., Parkman Professor of Anatomy at Harvard University. 8vo, pp. 18. Boston: Cupples & Hurd, 1888. Paper. Price, 25 cents.

This interesting monograph upon the tibia and fibula, studied in their relations to each other and to the neighboring soft and hard parts, is the substance of a lecture delivered at the Harvard Medical School, Nov. 14, 1887. It contains a description of the shape and direction of various parts of these bones, and explains the mechanical principles involved in their reciprocal relations, and is illustrated with diagrams showing the bones in profile and in cross-section.

THE NATIONAL SIN OF LITERARY PIRACY. By Henry Van Dyke, D.D. Small 8vo, pp. 23. Paper. New York: Charles Scribner Sons, 1888. Price, 5 cents.

This little tract on what is now a burning question contains a sermon recently preached by Dr. Van Dyke at his church in New York. It is reprinted, and sold at a nominal price by the Scribners as a contribution to the discussion of international copyright, which is now going on in literary and commercial centres. Dr. Van Dyke takes a firm stand against the pillaging of authors which is so common on both sides of the Atlantic; but turns his attention especially to that which prevails in our own country. It is true that the English need such censure as he administers to our own countrymen as much as the latter do; but we agree with his obvious opinion that we should pluck the beam out of our own eye before undertaking any operation upon the eye of our brother. We share the growing desire in this country for an international copyright law, and welcome this effort to hasten its coming.

THE NEW YORK MEDICAL JOURNAL VISITING-LIST AND COMPLETE ACCOUNT BOOK. Prepared by Charles H. Shears, A.M., M.D. New York: D. Appleton & Co. Price, $1.25.

Our high regard for the *New York Medical Journal* makes it unpleasant for us to say what we think about this new candidate for professional favor. The publishers' opinion is that it is "without doubt the most perfect visiting-list ever offered to the profession, as it possesses all the advantages without the objectionable features found in all others." Our opinion is that it lacks the most important advantages of most visiting-lists, and, in fact, is not a visiting-list at all. It may meet with approval by physicians; but we think it will not. As a book, it is very dear indeed, at the price asked for it.

Pamphlet Notices.

Conservative Gynecology. By George F. Hulbert, M.D., St. Louis. From the *Weekly Medical Review*, Dec. 17, 1887. 10 pp.

Recent Advances in the Surgery of the Brain and its Coverings. By Charles B. Nancrede, M.D., Philadelphia. From the *Medical News*, Jan. 28, 1888. 28 pp.

Report on the Progress of Forensic Medicine and Toxicology. By Martin V. B. Clark, M. D., Sutton, Nebraska. *State Journal Company*, Printers: Lincoln, Nebraska, 1887. 16 pp.

LYSSA AND THE PASTEUR FIASCO. By N. E. BRILL, A.M., M.D., New York. From the *Journal of Comparative Medicine and Surgery*, January, 1888. 23 pp.

THE SIGNIFICANCE AND LOCALIZATION OF PAIN IN PELVIC DISEASES. By HENRY COE, M.D., New York. From *Gaillard's Medical Journal*, February, 1888. 10 pp.

CONTRIBUTION À L'ETUDE DE LA SYPHILIS DES FOSSES NASALES. PAR LE DR. E. J. MOURE, Paris: *Octave Doin, Editeur*, 1888. 12 pp.

SUB-PUBIC DISLOCATION OF THE LEFT FEMUR. By J. S. WIGHT, M.D., Brooklyn, N. Y. From the *Transactions of the Medical Society of the State of New York*, 1887. 4 pp.

—Dr. Hulbert's paper contains an argument against the procedure of divulsion of the cervix uteri, which he believes to be a pernicious practice. His argument includes a careful study of the anatomy and physiology of the uterus and of the mechanical principles involved in flexions and so-called stenosis. The latter he believes to be misunderstood by many gynecologists, and he criticises sharply the common illustration, by a bent tube, of the condition supposed to obtain in cases of flexion of the uterus.

—Dr. Nancrede's paper contains a very good summary of the present state of knowledge in regard to the proper way to treat injuries of the brain and its envelopes. The author, like most surgeons of the present day, favors active surgical interference in cases of actual or probable fracture of the skull, of wounds passing into or through the bones of cranium, of tumors, abscesses, morbid growths, and hemorrhages within it. He also favors operations for epilepsy when this seems to be caused by a removable mechanical irritant. We do not think that the surgical world will be as much surprised at his statements as he seems to fear they will be; for most of them are to be found elsewhere, and surgeons who read have had a fair a chance to get used to them.

—Dr. Clark's pamphlet contains a full account of his investigations in two cases of supposed felonious poisoning. In one, the poison used was arsenic, and in the other it was strychnia. In both cases the patients died, and a trial for murder followed. Both of the accused persons were acquitted on the ground that it was not proved that they had administered the poison. The details of Dr. Clark's analysis are interesting and instructive, and indicate the thoroughness with which he did his work, leaving no possible doubt of the presence and nature of the poison in each case. In the second case, he came near losing his life from testing an extract of the stomach—supposed to be strychnine—upon himself.

—Dr. Brill applies to the popular theories in regard to hydrophobia, and to the claims of Pasteur in regard to his preventive inoculations, an uncommonly keen analysis and criticism. It is still held by men of deserved eminence in the medical profession that hydrophobia is a specific, inoculable disease; and some of them still trust in the assertions of Pasteur in regard to his method of treating it. But the number of those who have studied both so-called hydrophobia and Pasteur's shifting announcements is increasing, and hydrophobia and Pasteurization are less the rage than they once were. It is to be hoped that hydrophobia will yet disappear—as witchcraft has disappeared—and that such works as this of Dr. Brill, which we strongly recommend to the attention of our readers, will be estimated, as it deserves to be.

—Dr. Coe's interesting paper on pelvic pain treats of the nature and character of this important means of diagnosis, and advocates the use of electricity to remove it. The author believes that pelvic pain originates more frequently in the perimetric tissues than in any particular organ, and that it may radiate from inflammatory foci in the peritoneum or connective tissue surrounding the pelvic organs. For this reason operations upon these organs may fail to cure the pain, which may be materially relieved by the use of electricity.

—Dr. Moure's pamphlet contains a detailed account of two cases of syphilitic lesions within the ala of the nose. In one of them the lesion was the initial lesion of syphilis—a chancre; in the other it was a syphilitic gumma. Both lesions are extremely rare in this situation, and great interest attaches to an authentic account of such well studied and well described cases.

—Dr. Wight describes the case of a man upon whom four barrels of flour fell, producing a sub-pubic luxation of the head of the left femur and a compound fracture of the right femur. The main interest in the history of this case is connected with the manner in which the luxation was reduced—being converted first into a thyroid luxation, which was then corrected by replacing the head of the bone in the cotyloid cavity. This method is not new; but Dr. Wight's way of carrying it out was more or less extemporaneous and worthy of imitation. It consisted in passing the patient's leg over the surgeon's right shoulder, and combining traction, adduction, elevation, and manipulation with the hands until the head of the bone slipped into the thyroid foramen, after which flexion of the thigh, abduction, traction, and rotation inward, brought it into its normal position.

LITERARY NOTES AND QUERIES.

[In this column the REPORTER will publish short items of literary interest and questions addressed to this Journal or its readers, and answers to them, in regard to any literary matters; books, authors, places and prices of publications, etc.]

—*The Annals of Surgery*, which has just entered upon its fourth year, under the management of Dr. L. S. Pilcher, of Brooklyn, and Dr. C. B. Keetley, of London, is the only periodical, published in the English language, which is devoted exclusively to surgery. Each number contains original articles, and admirable summaries of surgical progress, as well as able editorials on subjects of timely interest. *The Annals* are published monthly at St. Louis, in octavo form, about 80 pages, by J. H. Chambers, price $5.00 a year. We can heartily commend it to the attention of those of our readers who have an interest in surgery.

—Blizzards, apparently, are becoming ordinary occurrences in Dakota, for a Western exchange remarks casually that, "after a blizzard the other day," Dr. Wheeler, of Grand Forks, and a number of friends took a ride on the doctor's ice-boat, going at the rate of 23 miles an hour.

Correspondence.

Prescribing Druggists.

Editor Med. and Surg. Reporter:

I was called to-day to visit a patient seriously ill with pneumonia following measles, and learned that she had been taking for several days a "cough mixture" prescribed by an M.D. druggist for a *bad cold*, so that important time for treatment of her disease had been lost. Returning to my office I found in the Reporter, February 11, an editorial upon the subject of "prescribing by druggists," which prompts me to write a few lines —not because I believe it will mitigate the evil here, but in the hope that it may arouse others in the profession to demand our rights, and to teach druggists to confine themselves to their legitimate business. This can only be done by concert of action on the part of the profession; for so long as a few physicians pander to the mania of druggists for prescribing in order to secure their influence for patronage, so long will druggists continue the practice. They cannot do it for pecuniary gain, because usually a prescription would prove more remunerative than the medicine furnished. Druggists expect physicians to send their prescriptions to them, they do all in their power to deprive the physician of his fee. This is the pecuniary standpoint, but there is another of more importance, a druggist may have a diploma to practice medicine, but when he undertakes to diagnosticate and treat diseases from behind his counter, without examining the patients carefully, and sometimes without ever seeing them, he is assuming a very great responsibility, it is not only the harm his medicine may do, but there is important time lost; and if a physician is called and the patient dies, the credit of the result does not go to the druggist but to the doctor. If the public could only know the evil this prescribing over the counter entails upon the patient, no druggist—whether he be an M.D., Ph.D., or no D. at all—would dare do it. A druggist may say that if he do not prescribe, the patient and his patronage will go to another druggist. But if there were concert of action among physicians, druggists would soon learn that the patronage of the physician is worth the most. This is a growing evil, and as the profession is becoming more and more crowded, M.D.'s are entering more into the drug business, and competition for prescribing is proportionately increased. Our State and county societies should take some decided steps in the matter, and our legislatures should be petitioned for some law to protect the people. I venture the assertion that druggists to-day do ten-fold more harm in prescribing over their counters and selling quack and proprietary medicines than all the charlatan doctors combined.

Yours truly, B. P. Reese.

Staunton, Va.,
February 3, 1888.

Amylene Hydrate.

Editor Med. and Surg. Reporter:

Sir:—Where can I obtain amylene hydrate, and at what price?

Yours truly,
A. S. Maxson, M.D.

Milton Junction, Wis.

[Amylene hydrate is tertiary amylic alcohol. It is a clear fluid, of a camphoraceous taste and odor, soluble in eight parts of water, and in alcohol in all proportions. A convenient method of administration is with licorice:

Amylene hydrate,
Fluid ext. licorice.....āā..f℥j
Water, to make.....f℥j
Mix.

This may be given in a single dose; but Avellis, in the article referred to in the Reporter, February 14, 1888, p. 154, has obtained good results from doses of one half to two-thirds of this quantity. The drug may be obtained from any reliable chemist, at about 60 cents an ounce.—Ed. Reporter.]

Sudden Death in Typhoid Fever.

With reference to his letter in the Reporter, February 25, 1888, p. 220, Dr. Hunter writes that "the 24th day" referred to the day of the month, not the day of the disease, as the patient lived only fifteen days. His temperature on the fourteenth day of his disease (January 24) was 100½° F., not 101½°.

—*Public Opinion*, Feb. 11, 1888, states that a new gas has been discovered in Germany by Dr. Theodore Curtius, who has succeeded in preparing the long-sought hydride of nitrogen, amidogen, diamide, or hydrazine, as it is variously called. This remarkable body, which has hitherto baffled all attempts at isolation, is now shown to be a gas perfectly stable up to a very high temperature, of a peculiar odor—differing from that of ammonia—exceedingly soluble in water, and of basic properties. In composition it is nearly identical with ammonia, both being compounds of nitrogen and hydrogen.

Notes and Comments.

A National Pharmacopœia.

The following bill, relating to the publishing of a National Pharmacopœia, has been introduced into the House of Representatives by Mr. Samuel J. Randall.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That the Secretary of the Treasury shall, as soon as practicable, detail two officers of the Marine Hospital Service, and the Secretary of War shall detail two officers of the medical staff of the Army, and the Secretary of the Navy shall detail two officers of the medical staff of the Navy, for the duty of compiling and preparing a pharmacopœia, which shall be known as the National Pharmacopœia of the United States of America, and shall be held and accepted as the standard for the purveying, compounding, and dispensing of drugs or medicinal agents, and shall be taken as authority in the Treasury Department on all questions arising under the tariff laws of the United States with regard to the nomenclature, description, and purity of drugs or remedial agents, and shall further be received as evidence in the United States courts. And the matter contained in the said pharmacopœia shall be free for use by all authors and commentators for the benefit of the medical and pharmaceutical professions and of the community at large; and it shall not be lawful for any one to reprint and publish the said pharmacopœia as a whole.

Sec. 2. That the medical officers detailed as above provided shall invite the American Medical Association and the American Pharmaceutical Association at the next annual meeting, to form committees of not more than three members from each of the said associations, which committees, if so appointed, may co-operate with the above-named medical officers in the preparation of the said pharmacopœia, forming a board, which shall have power from time to time to add to its number as may in its judgment be necessary, and which shall elect a chairman and a secretary, and adopt such rules as it shall see fit for the expediting and perfecting of the said pharmacopœia, which, when completed, shall be printed under the supervision of the said board; and an edition of not less than five thousand copies shall be printed for use in the several departments of the government of the United States; and copies may be furnished to private persons in accordance with the provisions of section thirty-eight hundred and nine of the Revised Statutes.

Sec. 3. That for the purpose of defraying the necessary expenses of preparing the said pharmacopœia the sum of five thousand dollars is hereby appropriated out of any moneys in the Treasury not otherwise appropriated, and the same shall be disbursed under the regulations to be prescribed by the Secretary of the Treasury.

Sec. 4. That the said pharmacopœia shall be revised once in ten years, upon the plan embodied in this act.

Legal Relations of Attending Physicians to their Hospitals.

One of the staff of the Queen's Jubilee Hospital, London, was dismissed by the managing committee of the Hospital because he accepted an appointment in another hospital in which homœopathic methods are recognized as an optional mode of treatment. The dismissed physician, whose name is Millican, appealed from this action to the court. Mr. Justice Manisty, before whom the action was tried, animadverted strongly in his judgment on the course which the committee of the hospital had adopted. For this course he has since been rebuked by the Court of Appeals. The doctrine of the latter court was thus stated by the presiding judge: "As medical officer, he would have a license to use certain rooms and certain furniture in the hospital. He would have *only a license, and not an interest in the property.* It followed from that, whether the relation between the plaintiff and the defendants was a contractural relationship or not, the relation was a strictly personal relation. Even, therefore, assuming that the defendants committed a wrongful act in putting an end to that personal relationship, the authorities were clear that the plaintiff was not entitled to an injunction. The plaintiff must bring his case within the principles upon which Courts of Equity will give such relief. Assuming, then, that there was a contract here, Courts of Equity never dreamt of enforcing by injunction agreements that were strictly personal in their nature." Lord Justice Fry remarked: "The position of the plaintiff was twofold. He was a subscriber to the hospital, and so a governor; and that position was not interfered with. He was also a medical officer. It was not necessary to consider whether the appointment constituted a contract with him or not. But, if it did, it created a purely personal relationship."—*Lancet*, Jan. 21, 1888.

Can Asses Vomit?

An interesting physiological point, says the *Lancet*, Dec. 31, 1887, is now being discussed in Paris. M. Zola, in his last work, "La Terre," depicts an intoxicated ass, and concludes with an account of the animal in the throes of sickness. M. Sarcey has taken offence at this unpleasant piece of realism, and, in a review of the work, affirmed that the ass was incapable of being sick, and brought forward the evidence of a veterinary surgeon to the effect that the structure of the stomach of an ass renders vomiting impossible. M. Zola writes back, and turns the tables on his adversary by stating that he had read up the principles of equine or asinine physiology before venturing to describe the matter in question, and refers the veterinary surgeon to his studies. In point of fact, M. Zola is perfectly correct. It is commonly, but incorrectly asserted, that the horse and ass cannot vomit. It is true that they vomit rarely and with great difficulty; the reasons being that the stomach is small, that the œsophagus opens into the stomach much nearer the pylorus than in the dog or man; so that the cardiac portion forms a large sac, against which the contents of the stomach are pressed when efforts to vomit are made. The contents of the stomach are, moreover, usually rather dry, and do not remain long in the interior of that viscus; and, finally, the œsophageal aperture is small and highly muscular. The latter point is undoubtedly of importance, since horses, and we presume asses also, vomit readily enough when, by disease or operation, the cardiac sphincter is paralyzed. M. Zola, if not very delicate, at least studies his art.

Good Advice.

Rev. Dr. Dallinger, speaking with the double authority of a minister of religion and a man of science, has been saying a few words of good, sound sense to Yorkshire people about the mockery of prayer to God for the abatement of small-pox, without the diligent use of all human means to this end. There cannot be a case of small-pox in a community without blame attaching either to the patient or to those responsible either as parents or as guardians of the public health. It is averred that men and women, half recovered from the disease, have been going about in Sheffield in public vehicles, or to places of amusements. This is an outrageous breech equally of sanitary law and of scriptural law of consideration for others. Small-pox is a disease from which everyone may be absolutely protected by vaccination and re-vaccination, so that to have it is almost a crime.—*Lancet*, February 11, 1888.

Artificial Cow's Milk.

Le Concours Médical, January 14, 1888, says that Dr. Ledentu has communicated to the Society of Medicine of Trieste the following mixture, which seems to him to reproduce with sufficient exactness the composition of cow's milk. He has himself employed it with great success forty-four times in fifty-one cases of cholera infantum. The following is the mixture:

White of egg	℥iv
Oil of sweet almonds	℥viiiss
Sugar of milk	℥x
Carbonate of soda	gr.vi
Chloride of sodium	gr.iii
Neutral phosphate of lime	gr.viiss
Water	Oii

Make into an emulsion.

Acute Bright's Disease in Children.

In a paper on this subject read before the New York State Medical Society, on Feb. 8, 1888, Dr. A. Jacobi said that many cases run an insidious course, the temperature being low, and appearing lower than it is, for the incipient œdema lowers the surface temperature, and even the temperature taken in the axilla by the thermometer is deceptive. Œdema and dyspnœa are the first marked symptoms—œdema of the pericardium, lungs, glottis and brain. Increase of blood-pressure causes cerebral symptoms and cardiac trouble. Diarrhœa is also found. Sometimes the symptoms appear very suddenly—such as a sudden loss of sight. The urine contains albumin; although this is occasionally absent, and then the urine is scanty, of low specific gravity, containing very little urea. Casts and epithelia are found.

One of the causes of acute nephritis in the adult is wanting in children, for the arteries are not degenerated. The most frequent cause is the poison circulating in the blood in the acute infectious diseases, especially scarlatina and diphtheria, but it is very rare in typhoid fever, probably because the course of the latter is not so acute and the range of temperature during it is lower. Rheumatism is for the same reason also less frequently a cause, even when endocarditis is present. The author had seen it follow purpura, renal hemorrhage being one of the symptoms. It also complicates croupous pneumonia, and even catarrhal pneumonia and bronchitis. Irritant drugs cause it, and especially chlorate of potash.

Exposure to cold is a very frequent cause, and in these cases common symptoms are hæmaturia, or hæmoglobinuria, which may return with every fresh exposure. As to the prognosis of nephritis in typhoid fever it is sometimes bad, even fatal, but generally the patient recovers entirely. In scarlatina, chronic nephritis may result, or uræmia may set in early and cause death. In diphtheria, on account of the difference in the poison, the lower range of temperature, and the weak heart, hæmaturia is not so common. In some cases of diphtheria copious albuminuria may even be followed by improvement in the general condition.—*Medical Record*, February 11, 1888.

Formulæ for Eczema.

The following formulæ are from the *Zeitschrift für Therapie:*

℞ Olei cadini (*vel* rusci),
Olei olivæ.....āā ʒi
Lanolin. pur.....ʒiss

Or,

℞ Olei rusci,
Zinci oxidi,
Olei olivæ.....āā ʒi
Lanolini pur.....ʒiss
M. Sig.—For dry scaling eczema.

Lanolin is also especially advantageous in the form of inunction in all cases in which there is a dry scaling skin, and can be either used by itself, mixed with oil to bring it to the proper consistence, or in the form of the following ointment:

℞ Acidi boracici.....ʒj
Olei olivæ.....ʒi–ij
Lanolin. pur.....ʒiss

This borated lanolin ointment accomplishes excellent results in the different affections of the lips in children, which so frequently present themselves for medical treatment.

How to Preserve Ligatures.

Prof. S. W. Gross condemns the use of carbolized oil for preserving *catgut ligatures*, as it forms a nidus for germs. Ten per cent. carbolized water does the same thing unless changed every two weeks. He recommends the following way to preserve them: Take the animal ligature, prepare a 1 to 5 aqueous solution of chromic acid:

Acid. chromic.....ʒj
Aquæ.....fʒv
M.

Add one ounce of the above solution to five ounces of glycerine, place the ligatures n this solution, and leave them there for one week; then take them out of this solution and hang them up until they are perfectly dry. Placed in the following solution they will keep until needed:

Alcohol.....parts 15
Glycerin.....parts 1
Acid. carbolic.....10 %
M.

If thrown into a 1–1000 solution of corrosive sublimate a few minutes before using, they will become soft and pliable.—*College and Clinical Record*, February, 1888.

Emulsions with Saccharin.

This new drug seems to be obtaining a stronger foothold in England than in this country. A. W. Gerard, professor of pharmacy in the University College, uses it in emulsions, and prepares the following formulæ:

EMULSION OF COD-LIVER OIL.

To make an elegant preparation, with the odor and taste well masked:

Take of
Cod-liver oil.....4 fl. ozs.
Powdered gum acacia.....1 oz.
Oil of cassia.....4 min.
Oil of almond.....4 min.
Saccharin.....2 grs.
Water to make.....8 fl. ozs.

Mix the oils with the gum and saccharin in a dry mortar, add 2 fluid ounces of water in one volume, stirring till the emulsion is formed; finally, add sufficient water to make 8 fluid ounces.

EMULSION OF CASTOR OIL.

To make an emulsion in which the oil is well disguised:

Take of
Castor oil.....1 fl. oz.
Powdered gum acacia.....3 drs.
Essential oil of almond.....2 min.
Oil of cloves.....1 min.
Saccharin.....1 gr.
Water to make.....4 fl. ozs.

Mix the oils with the gum and saccharin in a dry mortar, add 4 drams of water at once, stirring till the emulsion is formed; dilute to 4 ounces with water.

YOLK OF EGG EMULSION OF COD-LIVER OIL.

Take of
Cod-liver oil.....4 ozs.
Yolk of egg.....2 ozs.
Common salt.....25 grs.
Saccharin.....2 grs.
Oil of cloves.....8 min.
Water to make.....8 fl. ozs.

Rub the oils gradually with the yolk of egg, salt, and saccharin till an emulsion is formed, make up 8 ounces with water and shake well.—*National Druggist*, January, 1887.

Anomalous Features in a Case of Ovariotomy.

At a meeting of the San Francisco County Medical Society, December 27, 1887, Dr. O. O. Burgess reported a case of ovariotomy in a young woman, in which the operation had been rendered very difficult from the peculiar anatomical arrangement of the parts. The two ovaries had coalesced and degenerated so as to form one tumor, from each side of which a tube, which at first sight resembled intestine, but was afterwards found to be Fallopian tube, passed to the uterus, while from the vertex of the tumor a fibrous band passed upwards and gradually disappeared in the peritoneum. The fact that the displacement of the uterus was congenital, its descent having been prevented by the fibrous band, made it very strange that there never had been any disturbance of the menstrual function.

Another interesting part of the history of this case, is the fact that menstruation has been regular since the operation.—*Pacific Med. and Surg. Journal*, February, 1888.

Warning Apparitions.

In an article entitled: "Have ghosts been seen?" in the *Cosmopolitan*, January, 1888, Mr. Richard A. Proctor discusses the scientific status of the stories of apparitions seen at about the time of the death of friends or relatives, and the explanation offered in regard to them.

The coincidence explanation, he says, which disposes fully of even the best-authenticated ghost and goblin stories, fails entirely in the presence of the phenomena we are considering. Professor DeMorgan, a master of logic, long since pointed out its absurdity as thus applied. Among the multitudinous sights and sounds that, under favoring conditions, may be mistaken for apparitions and their utterances, a considerable number is bound to be strongly deceptive (the human mind being what it is), and there cannot but be some that seem to escape all explanation. But the special characteristic of the influences and appearances we are considering here is that they are so unusual as to convince the persons affected that something of a dreadful or most impressive nature has affected a dear friend or relative, and they are almost always, if not invariably, confirmed by the event.

As to the question of fact involved in these stories, he says: "It appears to me that the evidence regarding the communication of impressions from mind to mind over great distances, in such sort that apparitions of distant persons dying or suffering seem to be seen by their friends or relatives, is too strong to be rejected by any conscientious student of facts." He believes that science is no more justified in rejecting this evidence merely because no explanation is available than astronomers would be justified in rejecting the observed fact that bodies influence other bodies from a distance, merely because, as Newton himself admitted, no one can explain how matter can act where it is not. Some communication, he says, there must be between sun and planet, between planet and satellite, and beyond each solar system between sun and sun and between galaxy and galaxy; but no one has yet shown what that communication may be. In like manner, even the most cautious student of science may well believe that there may be some means of communication, under special conditions, between mind and mind at a distance, though no one may be able to explain how such communication is brought about.

For Chapped Hands.

The *American Druggist* recommends the following formula:

White wax	℥xiv
Spermaceti	℥iij
Cocoa butter	℥ix
Castor oil	℥ix
Oil of benne	℥vi
Melt and mix; then add glycerin	℥ij
Perfume as desired.	

This makes quite a nice preparation. Petrolatum is used instead of the oil of benne (sesame oil) by some, and is considered an improvement. Either, however, will do.

Pruritus Vulvæ.

An application which has proved of the greatest possible service in this obstinate and distressing affection is composed of

Cocaini hydrochlor	gr. xv
Aquæ destillat	q.s. ut ft. sol.
Lanolini	℥ss

This is to be applied to the itching parts.

For chronic Pelvic Peritonitis.

Dr. Cheron recommends:

Ammonii chloridi	℥iss
Syrupi aurantii cort	f℥vi

M. Sig.—One to five tablespoonfuls daily in water.

Putrid Diarrhœa.

Bouchard's formula is:

Naphthalini, Sacchari	āā ℥iss
Essentiæ bergamot	gtt. j–ij

Div. in chart. No. xxv. Dose, one powder every hour.

Photographing anatomical Preparations.

A novel and interesting application of photography was made in Philadelphia recently, and consisted of the photographing of anatomical subjects at night, immediately after their dissection. This was the experiment tried at Dr. George McClellan's "Pennsylvania School of Anatomy," on Tenth street, above Walnut. Dr. McClellan complained that the drawings which he had been able to obtain, while the finest of their kind, were idealized too much and did not present the subject as the student finds it. He also said that the tissues change so rapidly when exposed to air that photographs, unless taken immediately after dissection, gave no adequate idea of the objects, and the light in the clinic hall was of such a character that photography by the ordinary methods was out of the question. Mr. Buchanan undertook to overcome the difficulties by doing the work at night, and with the artificial light compound. The camera was focussed by aid of the light from a match, and very rapid plates were used. About 50 grains of the compound were placed on the edge of a small iron shovel and held a little behind but on the level of the lens; and, after the plate-holder slide had been withdrawn and the lens uncapped, a light was applied to the compound. There was a blaze of intensely white light, lasting for about one-tenth of a second, and the exposure was complete. Six plates were used, and in the cases of three or four a screen of tracing muslin was hung between the flash and subject. The plates were developed the next day and proved to be excellent printing negatives, the details being brought out so sharply that the prints are pronounced to be of very considerable scientific value.—*Ledger*, December 30, 1887.

Gargle for Chronic Pharyngitis.

Endler recommends the following solution as a gargle in chronic pharyngitis:

Zinci sulphatis.....gr. xv
Aquæ menth. pip.....f ʒvj
M. Sig.—Use as a gargle four times a day.

He says that his own pharyngitis which had existed for three months, was cured after using this solution continuously for eight days; and that his patients obtained the same successful results. In especially sensitive persons a weaker solution may be employed. —*Berliner klin. Wochenschrift.*

—Diarrhœa and cholera morbus are said to be epidemic in Minneapolis, Minn.

NEWS.

—Emile Rousseau, the eminent French chemist, died on February 6. He was 72 years old.

—Small-pox which has been epidemic in San Francisco, has now become scattered throughout the State.

—A new medical journal is announced to appear in Berlin under the title of the *Berliner Clinik*. Prof. Fürbringer and Dr. Hahn are the editors.

—Professor Brunetti, of the University of Padua, Italy, was recently suspended by ministerial decree, on the charge of inciting the students against his own colleagues.

—The Italian troops at the seat of war in Abyssinia are suffering from fever and intestinal affections, due, it is said, to the continued rainfall, succeeded by sudden elevations of temperature. Of the 18,000 men composing the expeditionary force, about 1,000 are in hospital. The death rate, however, is still very low.—*Lancet*, Feb. 11, 1888.

—The *British Med. Journal*, January 28, 1888, states that Mr. Thomas Godart, late Librarian of St. Bartholomew's Hospital, London, died November 5, 1887, at Sydney, New South Wales, whither he had gone on account of ill-health. He assisted Mr. Luther Holden by engraving the lithographs for Holden's *Osteology*. The best specimens of Mr. Godart's skill are his colored pathological drawings.

—The *American Lancet*, February, 1888, says: Of the one thousand physicians in Louisiana, only one hundred and seventy-six are members of the State Medical Society. Only about half the counties have representatives in the State Society. Why is this, when across the river in Texas the profession is organized with wonderful completeness? There is a chance for some missionary work in the profession of Louisiana.

—Rev. Dr. Leonard Bacon is vigorously assailing, and Rev. Dr. O. H. Platt is as valliantly defending, the faith cure, at Waterbury, Conn. Both are doctors of medicine as well as of divinity, but thus far the faithists have been unable to cure Dr. Bacon of his skepticism. In Jersey City, N. J., a butcher, John Elsey, was cured, or thought he was, of a bronchitis by this simple method, and he has erected a chapel in that city as a mark of his gratitude.

—A physician was recently charged before a Berlin court of justice with assault under peculiar circumstances. It seems that a boy four years old was brought before him

for treatment. Some local examination being necessary, the child began to scream and kick so violently that nothing could be done with him. After efforts to soothe him were entirely fruitless, the doctor lost patience and spanked him. The court held that the doctor had slapped the child with the object of doing him good, and dismissed the case.

—The Commissioners of Charities and Corrections of New York recently discussed a suggestion that the bodies of the unclaimed dead should be cremated, instead of buried, as is now done. The commissioners wrote to Corporation Counsel Beekman asking his legal advice as to whether they had authority to make such disposition of those bodies. He has answered that they have not. The Commissioners are required to bury all such bodies in the usual manner, except when they are authorized to give the bodies to medical colleges.

—The *British Med. Journal*, January 28, 1888, reports that on Friday, January, 13, Dr. Eustace, a young practitioner at Alresford, Hants, was summoned at midnight, and found a patient suffering from uterine hemorrhage. This he stopped, but in the morning the patient was almost pulseless and sinking fast. Dr. Eustace, with no one to help him but an old woman, opened a vein in his arm and tried direct transfusion, but lost a quantity of blood. He then allowed over six ounces of blood to drop into a basin, injected it with a syringe, with the result that the patient recovered.

—The Seventh German Congress for Internal Medicine will be held at Wiesbaden from April 9 to April 12, 1888. Herr Leube of Würzburg will preside. The following subjects are to be discussed:

Monday, April 9.—Chronic diseases of the Heart muscle and their Treatment; Oertel of Münich, and Lichtheim of Bern. Tuesday, April 10.—Alcohol as a therapeutic Agent; Binz of Bonn, and Von Jaksch of Graz. Wednesday, April 11.—The Prevention and Treatment of Asiatic Cholera; Cantani of Naples, and August Pfeiffer of Wiesbaden.

The following addresses are already announced: Rumpf (Bonn), Floating Heart; Unverricht (Jena), Experimental Investigations concerning the Mechanism of Respiration; Adamkiewicz (Cracow), Combined Degeneration of the Spinal Cord; Jaworski (Cracow), Experimental Contributions to the Dietetics of Digestive Disturbances; Stiller (Budapest), Therapeutics of Basedow's disease, and the Diagnosis of Tumors of the Kidney.

HUMOR.

FLIMSEY—"I don't know how it is, but the smallest specimens of men invariably get the best wives." Mrs. F. (archly)—"Oh, you flatterer!"—*Boston Transcript.*

A CORRESPONDENT of a New York paper asks: "Can you give a young lady a cure for malaria? She lives upon filled-in ground." "Filled in ground" must be an unsatisfactory diet. She ought to try pork and beans.—*Pittsburg Chronicle.*

A YOUNG PREACHER picked up Bishop Pierce's hat and put it on his own head, and it was exactly a fit. "Why, Bishop," said he, "your head and mine are exactly the same size." "Yes," replied the Bishop, "on the outside."

CHRISTIAN SCIENTIST.—"Have you ever tried the faith cure for your rheumatism?" Patient.—"Yes, I'm trying it now. I've got in my pocket the left hind foot of a graveyard rabbit that was killed in the dark of the moon, and I'm blamed if I don't think it's helping me.—*N. Y. Sun.*

THE CHRISTIAN SCIENTISTS would have us believe that what we call pain is merely imaginary; but hang the imagination that keeps a fellow awake all night when he has a felon on his thumb! And we don't suppose it would it do any more good to poultice the imagination than it would the thumb.—*Norristown Herald.*

SCIENTISTS say that shutting the eyes makes the hearing more acute. This explains why a man can't sneak into the house at midnight and crawl up-stairs as noiselessly as a feather without being heard by his wife, who is asleep. If women were to sleep with their eyes open, married men would have more fun at the lodge when there is a protracted session.—*Norristown Herald.*

"THE FACT IS, doctor, I can't sleep at nights; have a pain in my chest, and my stomach is all wrong." Doctor (feeling his pulse)—"What is your business, sir?" He—"I am a broker and a member of the New York Stock——" Doctor—"Never mind the balance. I understand your case thoroughly. Here take this (slips a dollar into his hand) and go and get something to eat."

THE SICK EDITOR.—Doctor (to professional nurse)—"Well, how is he this morning?" Nurse—"Weaker, doctor. Been very sick all night, and looks like he was comatose." Doctor—"Hows his temperature?" Nurse—"One hundred and two degrees." Doctor—"How's his circulation?" Editor (with

a fearful yell)—"Biggest in ~~New York~~! Biggest in the universe! Want an affidavit?" —*Burdette.*

When "Aunt Betty" Brooks, of Pike county, Pa., celebrated her one hundredth birthday on the 2d inst., she caught a cold, which caused her death. This shows that the celebration of one's one hundredth birthday is attended with some danger. If "Aunt Betty" had died in her ninetieth year, she would have escaped that fatal cold, but we don't suppose she thought of that.—*Norristown Herald.*

A Compliment to American Skill and Ingenuity.—*Journal de Pharmacie d'Anvers* gives a full account of the Newark artificial egg manufactory of New Jersey. This triumph of American skill has been received with amazement on the Continent of Europe. The author states that the eggs are so nearly perfect in appearance and taste that it is only a matter of time when the domestic fowl will be banished from the barnyard. It is expected, in the near future, that the problems of life will be solved by these eggs, when properly heated, bringing forth well-feathered chicks.

OBITUARY.

MILTON B. MUSSER, M.D.

Dr. Milton B. Musser, a well-known physician of West Philadelphia, died March 2, 1888, in the 42d year of his age. He had had symptoms of heart failure for some months before his death. Dr. Musser came of a family of physicians—his grandfather, great-grandfather and uncle were physicians, and a brother and a number of cousins are now in active practice. He was graduated from Jefferson Medical College in 1868, and at the time of his death was attending Obstetrician to the Philadelphia Hospital, a member of the College of Physicians, of the County Medical Society and of the Obstetrical Society of Philadelphia. He leaves a wife and three children.

L. M. SERVICE, M.D.

L. M. Service, a well-known physician, of Philadelphia, died February 27, 1888, at the age of 68 years. He was born in Washington county, Pennsylvania, and in early life was a school teacher. He was graduated from the Jefferson Medical College in 1848, and from that period until within a short time of his death he had an extensive practice in Philadelphia, Montgomery and Delaware counties. He leaves a widow, three sons and one daughter.

D. ELLIS BYRD, M.D.

Dr. D. E. Byrd died January 25, 1888, at Marvell, Ark., after a brief illness. He was graduated from the Richmond Medical College in 1863, and after serving as surgeon during the late war began practice in Virginia. In 1870 he removed to Marvell.

OTIS F. MANSON, M.D.

Dr. O. F. Manson died in Richmond, Va., February 1, 1888, after a brief illness. He was 65 years old.

Official list of changes in the Stations and Duties of Officers serving in the Medical Department, U. S. Army, from Feb. 19, 1888, to March 3, 1888:

Lieutenant-Colonel Edward P. Vollum, Surgeon, granted leave of absence for four months, with permission to go beyond sea, and to apply for an extension of two months. S. O. 41, A. G. O., Feb. 20, 1888.

Captain E. F. Gardner, Assistant Surgeon, granted leave of absence for one month and twenty-one days. S. O. 41, A. G. O., Feb. 20, 1888.

Appointment:

Paul Shillock, to be Assistant Surgeon, with the rank of First-Lieutenant, Jan. 31, 1888.

Changes in the Medical Corps of the Navy, for the week ending March 3, 1888:

Surgeon T. C. Heyl, orders to the Receiving Ship "St. Louis" revoked.

Surgeon C. H. White, present duty continued to Oct. 1, 1888.

Surgeon T. H. Streets, ordered to the Receiving Ship "St. Louis."

Surgeon M. C. Drennan, ordered to the Receiving Ship "Vermont."

Surgeon G. R. Brush, detached from the Receiving Ship "Vermont" and to the "Pensacola."

Passed Assistant Surgeon Victor C. B. Means, detached from Naval Hospital, New York, and to the "Pensacola."

Medical Inspector A. A. Hochling, detached from the "Pensacola" and wait orders.

Passed Assistant Surgeon G. E. H. Harman, detached from the "Pensacola" and wait orders.

Passed Assistant Surgeon J. M. Edgar, detached from the "Pensacola" and wait orders.

Official List of Changes of Stations and Duties of Medical Officers of the U. S. Marine Hospital Service, for the week ended March 3, 1888:

G. W. Stoner, Surgeon, detailed as chairman of board for physical examination of officers and candidates, Revenue Marine Service, Feb. 28, 1888.

F. M. Urquhart, Passed Assistant Surgeon, detailed as recorder of board for physicial examination of officers and candidates, Revenue Marine Service, Feb. 28, 1888.

P. C. Kalloch, Passed Assistant Surgeon, relieved from duty at Pittsburgh, Pa.; ordered to Marine Hospital, San Francisco, Cal., March 2, 1888.

P. M. Carrington, Passed Assistant Surgeon, relieved from duty at Marine Hospital, San Francisco, Cal.; ordered to assume charge of Service at Pittsburgh, Pa., March 2, 1888.

J. J. Kinyoun, Assistant Surgeon, granted leave of absence for twenty days, Feb. 28, 1888.

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Communications.

MALARIAL PARALYSIS, MOTOR AND SENSORY.

BY G. ARCHIE STOCKWELL, M.D., F.Z.S.,
PORT HURON, MICHIGAN.

It is unquestionably true that there is no group of morbid affections which possess wider scope, or greater claim to attention, than the so-called *malarial* diseases, since they pertain to all regions of the globe, the remoter portions of the frigid zone, perhaps, excepted. The obscure relations of malaria to other diseases are frequently proven by the presence of its germ; a germ that, pathologically affecting the portal system to the general derangement of the circulation and nutrition, manifests itself chiefly through the medium of the cerebro-spinal system, its especial predilection being the nerve centres. The latter circumstance, and the consequent tendency to association with puzzling, anomalous, and alarming symptoms, as in so-called pernicious and cerebro-spinal fevers and anæmias, gives especial prominence and interest to all maladies pertaining to this group, and a study thereof demands not only intimate acquaintance with the laws of neuropathology, but also of the toxic effects of the malaria germ upon nervous tissues.

With regard to the latter, the phenomena upon which the student or practitioner is required to depend, are uncertain, since they scarce ever manifest themselves twice alike, or as possessing like relations. The contracted vessels of the skin, and the rigors associated with the cold stage are evidence of stimulation of the vaso-motor nerves; while increased temperature, flushed surface, full pulse, and the dilated vessels accompanying pyrexia, exhibit tissue paralysis, both nervous and muscular. The splenic and hepatic engorgements, or the diarrhœas and dysenteries that are so frequently the sequels of profound malarial poisoning, are derived from dilated and paralyzed arteries, and consequently excessive flow of blood to enfeebled tissue. With such evidence, we need not be surprised at encountering also paralysis of voluntary muscles arising from like causes and phenomena.

All experience with malarial poison testifies to its exceeding subtlety and especially depressing effect upon the nervous system; and not to mention *cretins*, the inhabitants of markedly malarious districts are invariably described as "feeble of body and lacking in mind." Trousseau says the varied and peculiar symptoms exhibited by marked intermittents or malarias can be explained only by referring to the effect of a poison upon the nervous system; and Erb adds, referring to poisons as a class: "They cause lasting paralysis, as a rule, only when their action is slow and repeated, more rarely when they are acute; they cause the most varied forms of paralysis and paraplegia from simple weakness and paresis to complete paralysis, * * * * with or without disturbance of sensibility."

Unfortunately, malarial disorders are seldom regarded as presenting anything new or novel; nevertheless the knowledge that several cases of functional paralysis—by which title I include *paresis*, *paræsthesia*, *anæsthesia* and *analgesia*—have obtained grave prognoses at the hands of medical men to the unnecessary alarm of the patient, and that text-books universally ignore these paralyses as such *per se*, emboldens me to contribute in some measure to the subject.

At the beginning of my professional career I located in the city, in Eastern Michigan, which is still my home; and though it is

less malarious than most portions of the Lower Peninsula, I have from time to time encountered numerous cases of sensory and motor paralysis, which were, unmistakably, of malarial origin. Recently my attention has been more especially called to this matter by a number of cases occurring in the practice of my brother, the imperfect records of which, as obtained from him, are here presented:

Case I.—D. C., male, age 40, day laborer. First seen October 16, when he was found to have lost control of both legs and feet. He had been employed for some weeks as a stevedore at one of the lumber ports of Lake Huron, and latterly had worked much "over time." Ten days before he was taken suddenly with weakness across the bowels, followed by nausea and headache. These symptoms passed away in a few hours, and he returned to his work.

The second day following, he was again seized in like manner, the weakness being general, and being suddenly followed by loss of control of the lower extremities, which were cold, blue and covered with goose-flesh. After a few hours there was improvement, but the paralysis remained, though it was less persistent on alternate days, while on the intervening days the weak spells recurred. The bowels were constipated, as they had been for some weeks.

Physical examination revealed the temperature of the paralyzed extremities to be considerably below the norm, and that, too, in spite of the fact that they had just been removed from a strong mustard bath. Sensation was present only along the anterior aspect (over the spine) of the tibia, and over the most prominent points of both external and internal malleoli. Ordered 1.30 grammes (about 20 grains) of calomel and 0.02 (⅓ grain) of podophyllin, with quinine muriate, and camphor monobromide, to be taken immediately. This induced free catharsis, when quinine and euonymin were prescribed in generous doses, along with an aperient pill (nux vomica, belladonna and compound extract of colocynth) to regulate the bowels. From this time out there was no recurrence of weakness; sensation and motion rapidly returned; and, eight days after the first visit, the patient was standing upon his feet, with good control of his limbs. Recovery perfect.

The following five cases exhibit disturbance of sensation more or less complete.

Case II.—Mrs. W. N. B., aged 40, was seen on March 8, and found in a cold damp room, which was her usual sleeping apartment; what little heat was obtained came from a stove in the next room. The house stood upon posts, without wall or cellar, and the floor of the chamber was markedly cold. One window, heavily shaded by trees, opened from this sleeping apartment toward the north; and the ground everywhere, even beneath the floor, was low, wet and marshy. The patient had been a dyspeptic for three years, and her stomach was yet weak. She had no appetite; and but little taste. She had also a foul taste in her mouth on rising; aching bones and cold damp feet at all hours, in spite of applied warmth; and complained of being perpetually tired and irritable, and of sensations of chilliness and flushes of heat alternately, which were most marked in the morning between six and nine o'clock. At the time of the first visit she complained of intense pain in the epigastrium, apparently neuralgic in character. Physical examination revealed no abdominal engorgement, no enlargement of the liver, stomach, or spleen; while her tongue had a whitish-brown coat. For a day or two treatment was directed toward mitigating the more urgent symptoms, especially the sensitiveness of the stomach. Meantime the unpleasant sensations described continued to assert themselves with more or less regularity, and, at about the same period each day. Suddenly, after little less than a week had elapsed, and at the accustomed hour of *malaise*, disturbance of sensation occurred which caused no little alarm: numbness seized upon the forearms, hands, legs and feet, and apoplexy was feared by the family. This, however, gradually disappeared after a few hours, leaving only a slight prickling sensation. Immediately, about twenty grains of calomel was administered, and when its effects had subsided, antiperiodics, tonics, and alcoholic stimulants were ordered. The patient now began to improve, though with occasional relapses during the recurrence of damp, chilly weather, which invariably appeared in the morning, and were accompanied by more or less paresis and anæsthesia. As her surroundings were unfavorable to recovery, she was advised to remove to another locality as soon as possible. This advice was acted upon, with the result of rapid gain in health and strength.

Case III.—A. L. H., cabinet maker, aged 29, was etherized on February 27, to have a broken and carious set of upper teeth extracted. The operation was tedious and severe, and was attended by considerable, though by no means excessive, loss of blood. Four days later, at midnight, the patient suf-

fered from what was supposed to be a paralytic stroke; his arms from the elbows to the finger tips, and his legs from the knees to the toes, were totally devoid of sensation. At about 4 P.M. that evening he had experienced a weak and tired sensation, with a general feeling of numbness, which on retiring seemed to pass away; but about 10 P.M. he was awakened by a slight rigor, which was succeeded by decided anæsthesia of the extremities, and numbness of the palate and gums; the latter, as he expressed it, "feeling like large potatoes," though no swelling was visible. For a day or two he had suffered with anorexia, weakness, vertigo, partial amnesia, foul mouth, constipation, and general lassitude. His living room was over the bank of a sluggish river, the ground being such that at this time of year it was continually damp and beyond reach of the sun's rays. His pulse was rather quick, and somewhat weak; his pupils were larger than normal, but responded readily to light; his tongue had a light brown coat. For two or three days there had been recurrences of the "weak feeling" at about the same hour in the afternoon. Under alteratives and antiperiodics, iron and alcoholic stimulants, the "weak spells" and numbness were delayed in appearance until a later hour in each day, and became at the same time less marked, until they finally disappeared. Nevertheless, as there was constant tendency to recurrence, owing to the unsanitary condition of his surroundings, he was advised to change his residence. When this was done, convalescence became more rapid, and recovery was soon complete.

Case IV.—Mrs. J. G., aged 65, ill for two months, and greatly dispirited in consequence. Her trouble began with a severe attack of neuralgia of the right side of her head and face, which came on suddenly in the morning, the points of suffering being in the region near the supra-orbital, infra-orbital, and mental foramina. Subsequently followed anorexia, nausea, lassitude, eructation of gas, foul mouth on rising, brown tongue, sensation of weight in the stomach, occasional palpitation of heart, ostealgia, and cold extremities. These manifested themselves every forenoon, and were generally preceded by a desire to yawn, gape, sigh and stretch, succeeded by slight irregular rigors and flushes of heat. The neuralgia was followed, and at times supplanted, by loss of sensation in the painful regions, more particularly in the vicinity of the mental foramen; at the same time there was paresis of the legs and feet, and entire loss of sensation in those portions of the forearms supplied by the ulnar nerves. These symptoms were most marked in the forenoon, though they frequently continued through the day for days at a time. Usually, too, there was a slight rise of temperature and pyrexia in the afternoon, the thermometer on a few occasions registering 106°; though the pulse rarely reached 103, and exhibited no marked weakness. Her dwelling was in an imperfectly drained portion of the city. Her sleeping apartment was very small (9 x 12 feet), and on the north side of the house, with only one window, and it was imperfectly warmed by a stove in an adjoining room. The ventilation was execrable, and a cold current of air could always be detected along the floor to a height of twelve or fourteen inches. The treatment was practically the same as in the preceding cases, and the tendency to recurrence was obviated by removal to a more comfortable and convenient dwelling. This patient had suffered from paralysis agitans of the right side for some years, but the manifestations of this present malady did not differ from those observed prior to this attack.

Case V.—J. B., merchant, aged 50 years; residing fifty miles away. About April 1 he began to awaken in the morning with a foul mouth, coated tongue, headache and languor, which continued until late in the afternoon. At times he observed a throbbing sensation in the top of the head; again, he would be troubled with vertigo and dizziness, with constant gaping and sighing. He was also irritable—a condition quite foreign to his natural disposition. His appetite was at no time disturbed, or, if anything, it was increased, and he had no tendency to distress or irritability of the stomach. His bowels were constipated; and he had irregular rigors, followed by flashes of heat. He often had a prickling sensation at the vertex, as if his scalp were "asleep," invariably followed by a throbbing synchronous with the beat of the heart, which terminated in increased cephalalgia. He first consulted my brother on May 11. Examination revealed a coated tongue covered with thick whitish-brown fur, and moderate enlargement of spleen, but nothing further which could be deemed abnormal; and the microscope exhibited no deficiency or excess of white or red blood corpuseles. There had been no disturbance of the heart's action save when cardiac depressants were administered; these invariably increased the headache. His urine contained a slight excess of urates, and an abundance of indican,—the latter being found in all the cases. The diagnosis was malarial poisoning, though at the time nothing

could be learned of his surroundings to substantiate it; ultimately, however, it was learned that a wet cellar extended under the whole of his house and store. Under treatment he improved decidedly and rapidly, and returned home apparently well, but with the caution not to over-exert or expose himself, and to look out for a recurrence of the attack a week later. These instructions, however, were forgotten, and as the week drew to its close he was caught in a north-east storm and the following morning was seized with paralysis of both upper and lower extremities, and numbness in region of the right mental foramen, which last, after twenty-four hours, partially disappeared. This caused great alarm, as it was supposed to be the forerunner of apoplexy. For several days the numbness that followed the paralysis exhibited a tendency to increase in the forenoon of alternate days, at which time there was increased *malaise* and rise of temperature; and the seventh day from the paralytic seizure, he suffered a second. He now returned to the city for renewed treatment.

Owing to repeated carelessness his recovery was retarded. The temperature in no instance rose higher than 99°; and the pulse never exceeded 96, except under special stimulus or excitement. Hot alcoholic stimulants, hot lemonades, and wraps thrown about him, relieved the attacks of numbness, in part, by provoking copious diaphoresis. He had a great antipathy to mercurials and cathartics, and the humoring of his whims caused less satisfactory improvement than could be desired. But finally, a large dose of calomel was administered, which provoked copious green evacuations; whereupon the last traces of numbness disappeared, and complete recovery took place in a few days.

Case VI.—Miss E. H., aged 16 years, was seen June 1. One year ago last Spring, she was seized one Thursday at noon with numbness and complete loss of sensation in her upper and lower extremities, followed in the afternoon by neuralgic headache and slight fever. On eight successive Thursdays these symptoms recurred with occasional variations or additions and a loss of sensation in palate, tongue, and left side of the lower portion of the face, more particularly over the mental foramen; while enduring such attacks she could not pronounce certain words, more especially those well supplied with linguals. Her intellect was generally clear, and never more than temporarily dulled. Sometimes there was more loss of sensation in the left extremities than in the right, and on several occasions the left thigh was also involved. While these attacks lasted the sense of touch was so greatly in abeyance that prehension was often impossible, or at best accomplished only under the guidance of vision. Other prominent symptoms were: vertigo, ostealgia, languor, and tendency to amnesia, and to gape and stretch. After undergoing prolonged treatment at various hands without benefit, she recovered spontaneously with the advent of sultry weather.

When she presented herself for advice, twelve months later, she was suffering with a second attack, which began a week earlier than the first, and with headache, lassitude, and fever in the afternoon, followed by paralysis. One day the numbness would be more marked upon one side than the other, or perhaps wanting on the right side; once the left side of the mouth was paralyzed, the loss of sensation being most marked over the mental foramen. Variation of pulse and temperature were not marked, and sometimes wholly absent. Inquiry revealed the fact that she resided over a butcher's-shop, where large quantities of ice were stored for the preservation of meat; and the back room on the lower floor was frequently employed for rendering fats and other refuse. The case yielded readily to antiperiodics, and hepatic stimulants, the effects of which were materially assisted by the sudden invasion of warm, dry, weather and a "change of residence."

In addition to the foregoing cases of Dr. Charles Bliss Stockwell, I will mention one occurring twenty-four years ago in the practice of my father, Dr. C. M. Stockwell: A child six years old had suffered with intermittent fever for a fortnight or more; and was relegated to the care of one of the numerous dames infesting every community, possessed by a mania for dabbling in physic. It was suddenly attacked with hemiplegia, when a physician was summoned, and it made a rapid recovery under the exhibition of antiperiodics.

In reviewing the foregoing cases of functional nerve disturbance of malarial origin, it may be observed that the malarial poison produces various functional perversions of the nerves of the extremities, varying from slight coldness and numbness, on the one hand, to complete loss of both sensation and motion on the other. In five of these cases all four extremities from the elbows and knees, were involved; in one, the lower extemities alone; and in the other, one upper and one lower extremity. In two cases there was both motor and sensory paralysis. The regions over the mental foramen were involved in two cases, on the left side, and in

one upon the right. The tongue and palate were attacked slightly in one case and markedly in another.

Low, imperfectly drained surroundings, cold and damp weather, over-exertion, and worry, aid materially in the production of the malady just described, and also in retarding convalescence. Warm, moist or dry weather, on the contrary, facilitates recovery. All of these cases occurred in the Spring, late Winter or Autumn. As is a general rule with masked malarias the attacks, save in one instance, came on before noon, and invariably exhibited but slight elevations of temperature. The less the amount of fever the greater were the manifestations of the neuralgia; and the pulse differed little from its normal rate. The intellectual faculties were disturbed in but two instances, and by no means markedly so; however, in my own experience I recall three cases of complete, though merely temporary loss of memory, and one of deafness. Tenderness over the spine was rarely, if ever discovered, even by the most critical examination; and recovery was complete, including restoration of function and sensation in every instance.

After studying the different "Systems of Medicine" and works devoted to practice at my command—Niemeyer, Watson, McClintock, Tanner, Trousseau, Fothergill, Reynolds, Aitken, Flint, Pepper, Ziemssen, etc., I find nothing beyond bare statements that, in rare cases of malarial poisoning, paralysis *may* supervene; and a few remarks of Erb, quoting from Hertz (Ziemssen's Cyclopædia), under the caption of Intermittent Spinal Paralysis. The latter embraces the two cases of Maccario: 1. A woman suffered an attack of paralysis and anæsthesia of the extremities and tongue, two days after parturition; symptoms repeated in quotidian type for three days; yielded readily to quinine. 2. Male, 64 years of age, had a sudden attack of paralysis of the lower extremities and sphincters, but without loss of sensibility. The following day he had recovered sufficiently to void urine, and walk with difficulty, complaining only of general weakness. The third day paraplegia recurred, and on the fifth day he recovered.

Voluminous periodical literature, embracing a period of half a century, was also consulted, and with nearly as meagre results. In *Braithwaite's Retrospect* for 1857, Dr. C. Hanfield Jones cites two cases from Dr. McCullough: Both were members of a family residing in a malarious district, nearly all the members of which had suffered with intermittent fever of the ordinary type. These, however, were attacked with paralysis, one of the leg and thigh, the other of the arm, which disappeared spontaneously, with establishment of an ordinary quotidian intermittent.

Again, in a monograph devoted to functional nervous disorders, Dr. Hanfield Jones mentions the case of Mr. Stewart, an old Peninsular and Waterloo officer who was attacked with nervous pain in the head and hemiplegia of the left side. Power was lost, but sensation remained, though it was somewhat blunted. The pulse was 100, weak and small; and the intellect clear. An hour after the attack he had a slight rigor, followed by perspiration. The hemiplegia gradually wore off, but recurred, as slight attacks, at intervals, on alternate days during the following week. Under antiperiodic treatment, recovery took place. Dr. Jones mentions also the case of a man 20 years old, who was ill one month with "inflamed sore throat," after which paralysis supervened, the legs being weak and cold. He had no pain, no tenderness of spine; his sphincters were normal, his intellect clear, his skin cold, his pulse natural, his tongue white, his heart sounds normal, his urine healthy, but high-colored. His residence was wet and damp; no indication of disease of nerve centres. He recovered on the 28th day, under quinia, strychnia, mineral acids and porter. The phenomena of vaso-motor paralysis were well marked in the skin and in the mucous membrane; and it is conceivable that the vessels of the nerve centres were in a state of spasm, and that the paralysis depended upon nerve anæmia. The primary cause undoubtedly was a malarial miasm acting upon an average system.

Two more cases are noted by the same author in the *Lancet* for 1856, of which he says: "They appeared to be ordinary neuralgic affections of the upper extremities, peculiar only in this: that the motor nerves of the muscles were involved to a considerable extent, and not the sensory."

My own experience leads me to believe that malarial paralysis usually tallies more or less definitely with the history of ordinary intermittents; yet this is not always the case. I recall two cases of dengue or "break-bone fever," in which the prodromata and course closely resembled this disease. Another was at first mistaken for manifestations of heat-stroke; and still another, had positively no symptoms aside from the paralysis, which occurred and disappeared coincidently with an urticaria. Occasionally, too, the cases are prolonged and stubborn, yielding indifferently

to ordinary antiperiodics, but amenable to arsenic in *large* doses, strychnia, or oil of parsley. Marked relief is also had from diuretics, especially if there is a tendency to profound anæmic hyperæsthesia (neuralgia).

Before closing this paper let me call attention to the close analogy existing between malarial pyrexia, neuralgia, and functional paralysis, which accounts for the frequency with which one is replaced by, or merged into the other.

The essential phenomena of pyrexia, whether of malarial origin or not, are: Increase of temperature; derangement of nervous function; disordered secretion; and impoverished nutrition generally. No physiologist need be told that any one or more may preponderate, perhaps to the total exclusion of others. Derangement of nerve function may, and does, induce paralysis—and that, too, without accompanying fever—and they are frequently seen in acute maladies. Hence, their appearance without pyrexia, in malarial disorders, should be no cause for surprise. Fever is often present, but it is so moderate as to escape the attention of patient or attendants, and is discovered only by visits at unusual and irregular hours: in the malarial remittent of the young, the febrile paroxysm is almost invariably nocturnal. Again, fever may assert itself as a neuralgia only, the intimate connection of the two being shown by their amenability to precisely the same remedial agent. At times fever and neuralgia are alike replaced, or accompanied by some form of motor or sensory paralysis: paresis, paræsthesia, anæsthesia, or analgesia. Involvement of the vaso-motor nerves causes pyrexia; and the different degrees of involvement produce the different conditions of neuralgia and paralysis. This is a physiological axiom, in accordance with which we find Pepper describing loss of sensation as a sequel of pyretic action dependent upon disordered portal circulation and consequent indigestion, and C. Handfield Jones asserting that neuralgia is but a form of febrile paroxysm, "the morbid phenomena being determined by the part upon which the poison fixes." Romberg describes pain as a cry of the nerves for good blood; nutrition being but ill-performed, the nerves undergo a form of molecular alteration which constitutes pain. What is true of anæmic hyperæsthesia is equally true of paralysis. Damp, cold, malaria all act in precisely the same way, by deranging the molecular nutritive actions of the nervous structure, and so unfitting it to fulfil its functions.

There are several circumstances which strongly support this view, chief of which is: 1. The frequent co-existence of pain with numbness, especially in highly sensitive parts. 2. The difficulty of differentiating the condition which produces pain from that causing numbness—the action of cold, for instance.

"It is clear," says Dr. Jones, "there is no opposition between them; both are present together, and the anæsthesia commonly remains as the more permanent condition in the intervals of the paroxysms of pain, and even after they have ceased to recur." Now numbness or anæsthesia is evidently a failure of functional power; and of the same import is the occurrence of various degrees of muscular paralysis, or of paresis, paræsthesia, analgesia, etc., which may be, and are, associated with neuralgia, evidently as analogous affections of the motor and sensory nerves.

In this connection the phenomena of myalgia present an illustration of neuralgia, for here the intimate relation of pain to debility is most apparent; the sensory nerves of the muscles suffer because the associated motors are weak, and consequently whatever increases the debility, also increases the pain, and *vice versâ*. In many well-marked neuralgic affections, too, there is evident paralysis of the vaso-motor nerves at the seat of pain, and hence it is probable the sensory nerves are in like state. Again, the pain of a sensory nerve, and the paralysis of a motor nerve, may both be relieved by the same Faradic current. Finally, that a nerve which receives for its nutrition blood poisoned by malaria should be disordered in its functions and give rise to pain, is quite intelligible, since it is well-known that the general action of the malarial poison is chiefly paralyzing, as is shown by the fact that it causes weakening of voluntary power.

—The year 1887 will long be memorable in London for the extensive epidemic of this disease, which is still in progress, and for the successful part played by the fever hospitals of the Metropolitan Asylums Board in the treatment and isolation of cases. About the latter end of July the number of cases of scarlet fever in the Metropolitan Asylums Board Hospitals—which during the early part of the year had averaged between 400 and 500 at any one time—began seriously to increase. The number of cases under treatment reached a maximum of about 2600 in the middle of November, and is now undergoing a slight decrease. The type of the disease has been for the most part unusually mild, and the mortality correspondingly low. —*Brit. Med. Journal*, Dec. 31, 1887.

SUBMUCOUS AND SUBSEROUS FIBROIDS OF THE UTERUS, AND BONY DEGENERATION OF THE RIGHT OVARY. RECESSION OF THE INTRAMURAL TUMOR DURING TREATMENT. DEATH BY OBSTRUCTION OF THE BOWELS, FROM PRESSURE AND PERITONEAL INFLAMMATION.

BY ENOS T. BLACKWELL, M.D.,
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On December 20, 1886, I received a note from the late Dr. Elliston R. Bateman, asking me to visit one of his patients, Miss B., and stating that she had been taken, about a week previous, with intense abdominal pain, swelling, vomiting and marked constipation. He suspected localized peritonitis and ovarian disease; and requested that I should examine carefully, with especial reference to disease of the right ovary. I saw her in accordance with this invitation, alone, Dr. Bateman being unable to be present. The following conditions were noted at that time.

Miss. B. is 48 years of age, and has missed her menstrual flux for six or eight months; the flow re-appearing in the latter part of last month, and again at the present time. On Monday night, a week since, whilst turning in bed, she felt as if something gave way within the abdomen; and the following day, Tuesday, she had pain in that region, which became very severe. The part was also exceedingly tender. She had great thirst, nausea and vomiting. Her tongue was heavily coated, and the bowels obstinately constipated. The tenderness reached from the hypogastrium to the umbilicus, extending widely on each side the middle line. The affected space was hard, tender, dull on percussion, and had a well-defined border or edge. In the right iliac region is a tender spot, the size of an orange; distinct in its boundaries, and separated from the enlargement before described.

There is no fluctuation in either region. The pulse beats 112 per minute. I prescribed liberally of quinine, and alternated with laxative doses of calomel. A suitable external applicatian was also made. December 21, 1886. On this day, I again visited the patient in company with her attending physician. She sweated freely during the night; and her tongue is cleaner and her manner brighter. She has had a free evacuation of the bowels, and has eaten some toast. Upon making an internal examination, the vagina was found soft and extensible. The os is diffused—does not project any whatever, and just admits the uterine sound. It penetrated about one and a half inches; but could be introduced no further, though persevering efforts were made in all directions. The tumor in the hypogastrium seems to be a fibroid, attached to the posterior part of the uterus. The enlargement in the right iliac region is probably of the same nature, as no tenderness could be discovered in the ovarian region on internal examination. She was ordered the following:

℞ Ammonii chlor.....ʒj
Spt. ammonii arom.....fʒj
Extract. ergotæ fl.....fʒvj
Aquam.....ad fʒiv
M. S.—Teaspoonful three times a day.

January 22, 1887. Miss B. has an excellent appetite; her bowels are regular, the tongue clean, and her menstrual function upon her. The mid-tumor projects obviously forward. It reaches exactly to the line of the umbilicus—perhaps a trifle advanced beyond the point reached a month since. The tumor in the iliac space appears less prominent than at that time. She tolerates the medicine well, and is to continue as follows, viz.: 30 drops fluid extract of ergot after each meal, and 3 grains chloride of ammonium, in tablet form, before each meal. She continued these medicines for some time, assuring me whenever I saw her, that no increase in the enlargement had occurred; and, finally, believing that her trouble was at an end, left them off. She became very active in household work; and after wearisome labors, and some indiscretion in diet, she was seized, September 6, of this present year (1887), with severe colicky pains in the line of the transverse colon, and great nausea. To antagonize these symptoms, she was given morphia, salicylate of sodium, and carbolic acid: for the accompanying constipation she had 2 grains of calomel every two hours. On the day following, September 7, she, in addition to the mercurial, took podophyllin; the former medicine having failed to produce a movement. On September 8, she had podophyllin, leptandrin and compound extract of colocynth, in pill, with the extracts of belladonna and nux vomica. On the supposition that the morphia might retard action, chloral hydrate, 5 grains, in solution as required, was substituted. On Friday, September 9, the bowels still remaining unrelieved, croton oil, one to three drops, were given every hour, for three or four times in succession. This was omitted during the night, and resumed on the morning of the 10th. There was no movement downward

at the end of two or three hours, but a copious ejection of stercoraceous matter occurred by the mouth; and was repeated once or twice during the forenoon. She had been receiving enemas, at first simple, afterwards the more powerful, containing oil of turpentine; and, finally, croton oil was added. In the latter part of the day she received two quarts of cold water by enema; but no feces followed any of the procedures. Dr. Ephraim Bateman was now called in consultation, who advised a blister to the prominence in the right side of the abdomen, which was applied. Laparotomy was mentioned; but I did not understand that it was recommended. There was at this time a great deal of tympanites and obscure tenderness. She continued to take the chloral as before; and it gave her fair relief. The blistering plaster drew well; but the patient's abdominal trouble remained unchanged. She, however, manifested a desire for food, which she had heretofore declined. She took at long intervals about two ounces of strong beef-tea, and the same amount of infusion of coffee. She declined any attempt at alimentation by the rectum. The pulse at this time had a daily period of acceleration. It continued to quicken, and reached 118 at this day's observation. On Sunday, September 11, the condition of the patient was unchanged. On the morning of September 12, Dr. H. W. Elmer was called as consultant. At his suggestion a prominent coil of intestine was pierced through the abdominal wall by a hypodermic needle,and some foul gas escaped; but not enough to greatly change the aspect of the abdomen, which was tightly distended, showing several distinct lines of elevation, answering to the various coils of intestine beneath. By his advice, a specialist was called, with a view to a possible laparotomy. In the afternoon, from three to six o'clock of this day, the patient suffered great pain about the umbilicus; her nails were blue, and she lay in a cold sweat. Her pulse at 8 P.M., marked 122.

September 13. Miss B's fever continues much the same, pulse 122. In the evening she had mild delirium.

September 14. The patient has been fairly comfortable during the night, awaking frequently, but soon falling asleep. She takes liquids—table-tea and beef-tea. The pulse rate is 108.

September 15. Drs. M. Price and Burns, of Philadelphia, arrive at 11 o'clock A. M. The patient's condition being desperate; by their advice laparotomy was decided on, as a possible chance of relief to the strangulated intestine. Dr. H. W. Elmer, of Bridgeton, arrived at 1 o'clock P.M., and all things being ready, the patient was placed upon the operating table, after being fully anæsthetized with pure ether. The line of incision extended from the pubes to the lower boundary of the epigastrium. The tumor when reached was found attached by broad adhesions to the abdominal wall, and by many strong bands of false membrane to adjacent loops of intestine. Much time was occupied in breaking up these firm ligaments, and when at length the tumor was turned out, its uterine attachment, a slender, cord-like structure, was secured by a silken ligature; and, when severed, was allowed to drop into the abdomen. The intestines were of a very dark color, and the tympanites so great that much difficulty was experienced in confining them within. They had been continuously drenched with hot water during the operation, and the containing cavity mopped out with the sponge. When thoroughly cleansed a drainage tube was inserted, and the wound closed by the interrupted suture. The line of incision was freely dusted with iodoform, the parts covered with absorbent cotton, and covered in with a broad bandage. The patient's extremities were very cold at the conclusion of the operation, which lasted for an hour, and her circulation was very low. She was placed in bed, and well covered; bottles of hot water were freely applied about her person, and the subcutaneous injection of brandy, resorted to in the later stages of the operation, were continued. No blood to signify was lost in the removal, but the shock to the system was profound. Warmth returned to the body, but her strength failed, and her death occurred within the second hour after the conclusion of the excision.

Autopsy held September 17, at 3 o'clock P. M.: Dr. H. W. Elmer assisting.

On opening the body at the incision made in the surgical operation, the intestines presented themselves dark and very tympanitic. At the points from which they had been severed from the tumor, there was general roughening, and the remains of many strong neoplastic bands. From these ruptured parts there was sufficient oozing of blood to give them a raw appearance. On tracing the intestines throughout, there was found some thin excrement, but no occlusion. The uterus was thickened and contained a submucous fibroid about two inches in diameter, and was somewhat flattened antero-posteriorly. This was blended with the muscular structure in front and to the left, while posteriorly

and to the right it projected slightly from the inner wall of the uterus, and was there easily separable from it. Its tissue was of a dusky white color, very dense, and apparently destitute of blood-vessels. The cavity of the womb was somewhat enlarged, being estimated to hold one ounce of fluid. At the right superior angle of the fundus uteri was found a pedicle one and a-half to two lines in diameter and half an inch long, with the ligature as placed during the operation. This was firm and fibrous in structure, and occupied the position assigned to the Fallopian tube. About an inch beneath this there was a protuberant nodule, flattened and ovoidal in shape, and measuring in its horizontal, or greatest length, one and a half inches, and one and a quarter inches in the thickness. It was slightly embossed externally, and covered with a smooth, shining membrane, the peritoneum. On section it grated harshly beneath the knife, and the tissue on examination was found to consist largely of bone.

The uterus and accompanying tumors, when examined critically, were found to be as follows: The length of the former, exclusive of its neck, which is much thickened, is about three inches, and its thickness two and a half inches. Having been opened posteriorly in its axial line, the tumor presents within the muscular coat, with which it it closely blended in front and to the left. Posteriorly, it lies within the mucous lining, with which it is loosely connected. It projects very slightly into the cavity. Beneath the pedicle, already described, is the calcified tumor mentioned. It measures one by one and a half inches, and has a broad and thick uterine attachment. The tumor is whiter than the mural one—a light mulatto color. The calcareous deposits within appear to be in separate and distinct points, and concentric, as if precipitated from the inner walls of previously existing cysts. In the centre of one of these annular aggregations is a shallow cavity, which admits the button of a large probe. There can be no doubt, I think, that this tumor, from all its characteristics, is the right ovary which has undergone bony degeneration.

Attached to its anterior face, there is an enlargement the size of a chestnut, having also an appearance of concentric formations; but no bony structure. At the posterior inferior part of the womb is a tumor the size of a large hickory-nut, smooth externally, and covered only with peritoneum. It is easily separated from its bed by enucleation.

None of the tumors seem to have exercised any unhealthy influence on the patient's system, except the one removed by the operation. This had at different times, set up peritoneal inflammation causing effusion of plastic material, and resulting in the formation of adhesions and false-membranes, whereby the bowels were bound down, and securely held. The obstruction may have occurred by some sudden change in the position of the tumor, by which it was caused to press upon the bowels; or, by altering the relation of the constricting bands so that strangulation ensued. It may easily be inferred that peristalsis had been in constant liability of interruption from this cause; the great wonder being that interference with digestion was so long delayed.

The uncertainty of the location of the obstruction, and the great probability of complications from adhesions, the result of former inflammations, together with some family considerations, are mentioned as reasons for not advising early operation. That it could have been successfully performed at any time, in view of the extent and strength of the adhesions binding the various structures in such close union, can scarcely be maintained beyond controversy.

THYMUS VULGARIS IN THE TREATMENT OF WHOOPING-COUGH.

BY J. B. JOHNSON, M.D.,
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Few diseases are confronted by so large a list of remedies as pertussis. Its antagonists are arrayed in a solid column of thirty-six internal remedies, and nineteen by inhalation, and yet the disease does not evince a docility that renders it tractable to any great extent. When the disease terminates in health, the result is always satisfactory, but satisfaction has not always followed the use of the multitude of remedies offered by their respective advocates to control the disease; for in defiance of the influence of medicines proposed for its cure, it obstinately and contemptuously goes on, as it may elect, to the fourth or twelfth week of duration.

Rational medicine teaches that when therapeutics cannot control the duration or course of a disease, the next duty of the physician is to ascertain and select those remedial agents which present the greatest power to modify the force of the disease, and thereby render its presence tolerable and its continuance comparatively sufferable. When this end is attained in the treatment of a malady that has a given course to run, these remedies have accomplished all that a reasonable

expectation can demand; and the comfort of the patient is not only conserved, but the efficacy and power of such remedies are vindicated.

Those who have never used common thyme in the treatment of whooping-cough, may smile when I say that my experience in its use has encouraged me to such an extent as to say, that of all remedies I have used for the alleviation of this disease, a decoction of common thyme has given the greatest satisfaction. The simplicity of its preparation, its mildness of action, and peculiar sedative and anti-spasmodic effect in controlling the violence of the paroxysms of cough, is most astonishing. The little sufferers take the decoction without the slightest hesitation; and the benefit which they derive from it is as prompt as it is remarkable. It only needs a trial to establish it as the remedy, *par excellence* for pertussis. It reduces the paroxysmal character of the cough, and renders the disease milder in its force, and shorter in its duration. It diminishes, in a peculiar manner, that inflammatory condition of the mucous membrane of the glottis and the air tubes, which, in this disease—more than any other with which mankind is affected—invites reflex spasm. In the accomplishment of this object, the danger and liability to complications is very much lessened, and the disease rendered comparatively harmless through a marked diminution of the tracheo-bronchitis, which is always to a greater or less extent its constant attendant during the two stages of the disease.

The first stage is called the catarrhal; but this is sometimes absent. When present, however, it lasts about two weeks, and is then succeeded by the second or paroxysmal stage, which varies in duration from four to twelve weeks; and is very much influenced by the constitution of the child. Complications involving the head and chest are always to be expected where the lungs have been rendered unsound by tubercular deposits; and danger always attends whooping-cough when it attacks a child whose constitutional powers are weakened by scrofula. When complications do occur, they should be carefully watched.

In my treatment of this disease, I require my little patients to wear flannel—red or white—next to the skin, and be kept in a room well ventilated, the temperature of which should be kept at night, as well as during the day, at about sixty-five degrees in the winter season. They are not allowed to leave this room until restored to health. I direct an ounce of common thyme to be put into one pint and a half of hot water, and boiled down to one pint, then strained and sweetened well with either honey or sugar. In this manner, it is made pleasant to the child. To infants I order one or two teaspoonfuls to be given regularly every hour or two, and to children a tablespoonful every hour or two during the continuance of the disease. Should auscultation reveal much inflammatory action of the bronchial tubes or lungs, I usually add two drachms each of iodide of potassium and powdered chlorate of potash, to each pint of the sweetened decoction, and direct it to be used in the same manner as the simple decoction. Under the influence of this treatment my little patients pass through attacks of whooping-cough with astonishing ease and comfort, and only on rare occasions, have I been compelled to use any other medicines. This treatment is greatly aided by a prudent attention to diet, which should consist of milk and farinaceous foods.

CHOLERA GERMS DESTROYED BY AMMONIACAL GASES.

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I have the honor to give a brief note upon the subject of "Epidemic Cholera," as it appeared at Fort Dodge, Kas., in the summer and autumn of 1867. The fort is situated upon the upper Arkansas River, near the present location of Dodge City. The garrison was composed of a batallion of the 3rd U. S. Infantry, troop B of the 7th U. S. Cavalry, and quite a large force of civilians. In July, 1867, a detachment of colored troops, on their way to New Mexico, encamped on the river bottom near the fort. The moving column lost some of their command with cholera along the line of the march, and one died while encamped for the night near us.

Surgeon Chas. DeGroff and I took all the precautionary sanitary measures within our power to keep the cholera out of our command, but the second day after the colored troops had left a man who had visited the encampment was taken down with cholera, and in less than a week we had a dozen cases on hand. The rapidity and fatality of this dreaded disease had a depressing effect upon the most of the troops, and caused a stampede of many of the civilians and quarter master employées of the post.

DeGroff was soon prostrated with nervous fever, so that the whole care and responsi-

bility for the sanitary condition of the troops, employées of the post, and the entire management of the hospital department fell upon me. The first thing done was to move the sick men from the bottom to tents on higher ground; and to have them scattered as much as possible. Reliable nurses were so scarce that some—who proved most proficient—were taken out of the guard house: even criminals were released and were put on the volunteer force as nurses, with the understanding that if they were faithful and survived, their punishment would be mitigated.

The epidemic was at its height during the middle and latter part of August, and continued with slight interruption during the months of September and October. We had showers of rain during the warm season, but they did not refresh us, as the ground was so hot that as soon as the rain struck the earth it generated a hot steam which would almost suffocate a person obliged to inhale it. Most of the cases of cholera were taken suddenly, without premonitory symptoms, with cramps in the stomach and bowels; with a rice-water diarrhœa; and with continuous vomiting of about the same character. The blood seemed to cease to circulate in the extremities; the hands and feet got cold, and this coldness traveled towards the center of circulation, and as soon as it reached the heart the patient would die. Many of them died in less than eight hours from the time of first symptoms of invasion. The only rational plan of treatment gathered from this experience was to keep up the circulation in the extremities. This was most successfully accomplished by constant and continuous friction with the bare hands of some strong attendant. Small powders of morphia were given at short intervals to quiet the pain, and small bits of ice to allay thirst. No liquid medicine was retained for the first twelve hours. If we could keep a patient out of the stage of collapse for twelve hours our prognosis was generally favorable, as most of such cases survived and were ultimately cured. In all classes during the cholera epidemic there were some eighty-five cases with twenty-eight deaths.

One singular feature of this epidemic, developed during its rage, is worthy the serious reflection of scientists, as it may lead to as valuable results as did the discovery of vaccination. The feature of which I speak is, that Troop "B," 7th U. S. cavalry, was exempt from the cholera, while the infantry, the quarter-master's employées, the civilians, as well as the officers, and those living on ranches for a radius of seventy-five miles about the fort, were brought in for treatment. The fact that the cavalry troop was exempt from disease was not attributable to the choice of location of ground, for it was on the same level with the infantry quarters and not more than a few hundred feet distant.

The true explanation I believe to be as follows: At the time when the cholera epidemic prevailed the post was not completed, and the men slept in a stone stable with their horses; and it seems to me reasonable to believe that the cholera-germ was neutralized or rendered inert by the action of the ammoniacal gas arising from the decomposed urine of the horses. And it seems to me a practical benefit might be obtained from this experience if in case of a future cholera epidemic, we were to adopt the customs of the Arabs in this respect, or to spray our homes liberally and often with spirits of ammonia in order to destroy or prevent the propagation of the deadly cholera-germ.

MUSCULAR RELAXATION THE CAUSE OF SLEEP.

BY G. W. FUREY, M.D.,
SUNBURY, PA.

Among the factors contributing to wakefulness, muscular contraction and relaxation are most important. In fact, so long as there is any considerable contraction of the voluntary muscles, there can be no natural sleep, and almost complete relaxation of them is necessary to the production of sleep, this being in my opinion the active *cause*, and not the *effect* of sleep. It seems to me clear that the slowing of the venous circulation suppresses or suspends the activities of the nervous centres sufficiently to permit of sleep. Let us look at a few reasons for this belief. The propelling force exerted upon the venous blood by the heart's contraction, as well as by that of the arteries, is at most merely nominal, owing to the intervention of the capillary system, against which it is expended. Then, as all will admit, there are other agencies than the action of the heart in maintaining the flow of blood in the veins. The channels for the return of the blood from the extremities are peculiar, differing from the arteries as to numbers, situation and mechanical construction; being situated generally between the muscles, supplied with valves, and averaging two or more in number to each artery. Now the occasional or continuous contraction of the muscles exerts a pressure on the veins, which, owing to the presence of the valves and the

passive nature of the veins, propels the blood onwards to the heart. Sleep depends upon a diminution in the quantity of blood circulating in the brain. Every one has noticed the tendency to drowsiness after meals, and the sleep of drunkenness is at least partly due to paralysis of the arterioles and muscles of the body in general, which renders the general circulation sluggish. Determination of the blood to the organs of digestion after eating accounts for the after-dinner nap, and all students can bear witness to a relative clearness of intellect when these organs are at rest. All careful observers must have noticed the instinctive disposition to walk the floor, to clench the fist, or to perform some like contortion during forced or violent intellection. You who read this have doubtless often laughed at your friend nodding in his chair, and have noticed his inability to sleep until his chin had fallen forwards, and the book had slipped from his relaxing grasp. Did it ever occur to you that *gaping* is only an automatic governor to restore waning energy and wakefulness by simply accelerating the circulation? If you are very drowsy, as you sit in your office reading this, just lay it down a moment and take a good "stretch." What has happened? You have pumped blood from and to the brain. You are awake again. It is not possible to sleep while one's fist is clenched, nor while any considerable amount of muscular contraction exists. One is usually awakened or set to dreaming by *the movement* provoked by any noise or external agency. The sluggard's yawn does not suffice to fully awaken him, but if he be pulled out on the floor he will be "wide awake." In that state of exquisite miserableness called nightmare, in which the temporary cerebral depletion is sufficient to produce a mental shock and motor paralysis, and the most vigorous efforts of an only partially absent will-power are totally inadequate to break the spell, it is only necessary, in order to throw it off, to be able to contract the flexor muscles of the little finger, and restoration to wakefulness is the result. Usually, in order to sleep well, a certain amount of preparation is required. One will naturally choose an agreeable place, then assuming the most comfortable position, allow the limbs to arrange themselves, the eyes to close and sleep to supervene. What has happened is simply this: The veins of the body having been relieved of a great amount of muscular pressure, become a general receptaculum of blood, which is drawn off from the nervous centres.

You will ask how can this theory be reconciled with the peculiar conditions obtaining in somnambulism and nightmare, and especially why the movements made in sleep-walking do not awaken the walker? I cannot do so, for the reason that we are not possessed of a *rationale* of somnambulism. And, again, it is in no wise the condition we are considering—"Natural Sleep." But if we apply the theory we have been considering as the cause of sleep to nightmare, it will aid us very materially in understanding a very probable cause of that distressing and dangerous affliction of humanity. You are aware that one is much more liable to an attack of nightmare while lying upon the back, especially if he have gone to bed soon after eating a hearty meal. This is owing to the fact that the weight of the stomach, while lying in this position, opposes, by its unnatural pressure upon the ascending vena cava, the free return of the portal circulation, sufficiently to produce anæmia of the brain. This may be to such an extent as will result in death.

Hence I assert that, whatever the ultimate phenomenon may be, the proximate cause of natural sleep is *muscular relaxation.*

Society Reports.

PHILADELPHIA COUNTY MEDICAL SOCIETY.

Stated Meeting, February 22, 1888.

W. W. Keen, M.D., in the chair.

Dr. W. W. Keen read a paper on

A Case of Macewen's Operation for the Radical Cure of Hernia, followed by a Speedy Return of the Hernia.

I think it important to report failures as well as successes. Macewen's operation, also, has been so generally successful that it is the more important to report the failure of this case as the immediate result of the operation seemed to promise a cure; but, as you will see, the hernia has quickly reappeared. For the notes of the case I am indebted to Dr. Lambach, the Surgical Resident.

The patient is a man thirty-two years of age, a fresco painter, but for some time at work dredging oysters. When seventeen years old he first noticed a right oblique inguinal hernia, for which he wore a truss for a year and then laid it aside. The hernia remained cured for thirteen years. A year ago, while at work dredging for oysters, the hernia returned, and descended into the upper scro-

tum. He entered St. Mary's Hospital on the sixth of January, 1888, on account of the disterss and inability to pursue his occupation. The operation was done on the 13th; on the fifth day I removed five of the nine external stitches, and on the twelfth day the remaining four. There was no pus at any time. The highest temperature was 100.2°. He had then two chills, the first on the fifteenth day, his temperature rising to 103°; but as there was no evidence of suppuration, as it yielded promptly to quinine and arsenic, and as his occupation had exposed him to miasmatic infection, we were justified in attributing this to malaria. He was kept in bed for twenty-nine days—*i. e.*, until February 11th. At this time I examined him, and found the hernia perfectly cured. He was then allowed to get up, a spica and compress being applied. Examining him yesterday (February 21), I found the hernia had returned, with, however, one gain—at the time of the operation the external ring was very large, requiring four double sutures. Now it will only admit the point of the index finger. Moreover, he is exceedingly comfortable; so much so that I doubt if I can persuade him to undergo another operation.

The steps of the operation I will illustrate on this model:

An incision was made over the site of the hernia to its lowest point in the scrotum. With the blunt end of the scissors and the finger, the sac was then dissected from the surrounding parts, care being taken to leave no attachment to the spermatic cord. The index finger then was passed within the abdominal wall, and the peritoneum was dissected for half an inch around the circumference of the internal ring. A moderately stout ligature of chromicized catgut was tied to the lower part of the sac, and a series of stitches taken from the lower portion of the sac to its mouth. This stitch, by means of Dr. Ellwood Wilson's curved trachelorrhaphy needle, was then passed through the abdominal wall from within outward at a point a half inch above and external to the ring, the skin being drawn upward and outward so as to allow the stitch to emerge through the abdominal muscular wall, but not through the skin. The traction was made on this stitch, thus puckering up the sac, which latter was drawn through the ring and rested against the inner surface of the abdominal wall to become adherent there, closing the hernial opening by a firm pad. The stitch was then carefully secured in place. The external ring was then closed by four double stitches of choromic catgut, passed from side to side. I was extremely careful in denuding the inner surface of the abdominal wall to get a large raw surface at the internal ring, so as to gain firm union at that point; and the patient was kept on his back for four weeks; yet it gave way a few days after letting him up.

I shall repeat the operation if he is willing.

Dr. H. R. Wharton said, in opening the discussion, I have no personal experience with Macewen's operation for the radical cure of hernia, but I have seen two cases in which Agnew's operation was employed, and three or four in which McDowell's method was resorted to; these are subcutaneous operations, and do not compare with this open operation in thoroughness. The immediate results seemed good in the cases referred to, but in a short time the hernias were down again. Recent reports from England, though still too recent to allow us to estimate the permanency of the cure, are very encouraging. As to Macewen's operation, I think it one of the best that has been proposed, and if any radical procedure is to be undertaken it seems to promise the best results. Of course, any operation is more apt to be successful in children than in adults.

Dr. C. W. Dulles said: I would like to ask Dr. Keen if any appliance other than the bandage was used after the patient began to go about. The hernia looks as if it had been down some time, and not as if it had descended recently. I think it would be best not to trust solely to the strength of the tissues for a little while after these operations. There is a point in the mechanics of hernia which I have noticed, and which I have not seen described by others, and that is, that a patient with inguinal hernia usually has a pendulous abdomen. I was curious to see if the spare patient of Dr. Keen's would follow the rule, and I saw that he did. I may lay too much stress upon the matter, but I believe that the best appliance is not one which makes pressure over the ring alone, but one which corrects this abdominal outline, and changes the direction of the thrust of the intestines from one at right angles to the plane of the hernial opening to one parallel to its plane. The diagram which I draw on the blackboard illustrates what I mean. Such an abdominal supporter as women wear would answer the purpose, and I believe that it would add to the chances of permanent success after operations for the radical cure of hernia.

Dr. Keen said: Of the cause of failure, I can only say that apparently the reparative power did not suffice to obtain adhesion of the sac

to the abdominal wall. Why, unless the two chills referred to had some influence, I do not know. The usual practice of those who have had a large experience with these operations has been not to use any truss. I must take exception to Dr. Dulles's diagram. He is right as to the shape of the abdomen, and in correcting it to a more oblique outline, but the pressure will always be at right angles to the abdominal walls anteriorly, and not as he has it here, down into the pelvis. That would, however, correctly express the direction of the rebound. As to the exact time when the hernia reappeared I cannot say. When I examined him, February 15, four days after letting him up, it was not there. I did not see him again until February 21, when I found it had reappeared. I shall not wait long before repeating the operation. He wants to be earning wages, and I do not want to burden the hospital with any patient longer than necessary. Any danger will have passed over in a week or two, and I will then operate if he consents.

Dr. Dulles said: When we bear in mind the comparatively mobile state of the contents of the abdomen, we must see, of course, that the intra-abdominal pressure is exerted in all directions, and we might draw any number of arrows to indicate it; but there is only one direction of "*thrust*," which is the resultant of all the lines of pressure; and by supporting the abdomen, as I suggest, by a firm and comparatively unyielding support, we turn the direction of that thrust into a line following the axis of the pelvis, and take it off the ring.

Dr. Wm. S. Stewart read a paper on

An Improved Obstetric Forceps.

It is not my intention to consume the time of this Society by giving a history of the origin of the use of the obstetric forceps, nor to enter into a general discussion of its merits or demerits. I take it for granted that there is a large majority admitting their necessity, and the great benefit they are to the lying-in patient. Therefore, I will content myself in endeavoring to point out the advantages of having parallel handles, so that the application of either blade first can be made at will, as the exigencies of the case may require. It is in order to meet this necessity, which I have more than once experienced, that I have the honor and privilege of presenting for your consideration an instrument which will demonstrate its superiority, and consequently can be relied on in almost any emergency.

The improvement is not restricted to any special form of blade, but can as readily be applied to the straight as to the curved, its use being equally effective with either form. The first object, for which I was most solicitous, was to be able to have an instrument which could be used readily in presentations where it might be desirable to apply the second blade first, as sometimes in the second position of the head when jammed into the cavity of the pelvis and rotation to the antero-posterior diameter has been prevented by a narrow, contracted passage. In all such cases there will be no difficulty in applying and adjusting the first blade; but, occasionally, it is impossible to apply the second in this condition of the presentation, the only remedy being to reverse the order by applying the second blade first, running the risk of injury to both mother and child in the recrossing of the handles, in order that they may be locked before making traction. This we have overcome by having the handles made parallel to each other, without overlapping, as in the ordinary instrument. Each handle has its own independent lock, the two being connected by a plain bar, which will admit of adjustment no matter which blade is applied first.

To overcome the danger of slipping, and to secure the grasp on the fœtus, it was necessary to devise some method of reversing the direction of the handles, in order that traction could be applied. To accomplish this a double lever was devised, one part on each handle, and each working on the same pivot or fulcrum; to this the traction is applied, resulting in a power perhaps superior to anything we could have expected. The compression to the fœtus is no longer in propotion to the power in the grip of the hand applied to the instrument, as in the cross-handles, but is regulated simply by the resistance to be overcome, and beautifully illustrates the mathematical relationship between the force and the resistance; consequently, all fear of the slipping of the instrument is obviated, and the only force that is necessary to be applied is for the delivery of the fœtus, serving at the same time for compression and traction. The compression, however, is controlled by a shoulder which is made on the toggle-joint, preventing any risk to the child, and its limit corresponding to the position of the blades of the cross-handled instrument when the handles are in apposition.

Should there be any irregularity of application, and consequent difficulty in locking, we have devised a coned hub with a winged nut, which, though the handles may be at an angle of twenty degrees, enables us to adjust them accurately.

The advantages of this improvement, as experience has demonstrated, are summarized as follows:

First. The application of either blade first.

Second. The impossibility of the slipping of the blades when properly applied.

Third. Moderate and even compression, the degree of compression being regulated by the amount of resistance.

Fourth. Greater facility for making traction.

Dr. Longaker: The only advantage of this modification of Dr. Stewart's, is that the forceps is not so likely to slip. This is due to the parallelism of the blades, which is maintained even though the blades be not on opposite sides of the child's head, and in very large heads where it is difficult to recross the handles. There is in existence another device for the same purpose, a very simple one, a mortise lock at the end of the handle. Personally, I think the forceps introduced by Sir James Y. Simpson cannot be improved upon.

Dr. Packard: I ought, perhaps, to speak with some diffidence on obstetrical matters, as my practice in that line has of late years been but limited. Yet I cannot but recall the teachings of Professor Hodge, and the extremely practical instruction given the students of my day by Dr. Joseph Warrington, which found abundant confirmation in my experience. We were taught that the forceps should never be applied unless the os uteri was dilated or dilatable; that they should be introduced with the utmost gentleness, the surface of the child's head being the sole guide; that ready locking (and no force was ever to be used to effect this) was the test of proper application; that under no circumstances was any leverage to be exerted by means of the mother's tissues; that the left hand of the operator (applied at the lock, the tip of the forefinger against the child's head, to detect any slipping of the blades) should be the fulcrum, the instrument being then used as a double lever, so as, by a gentle swaying motion from side to side, to coax the child's head through the passage. This side to side movement was strongly advocated afterward by the late Dr. Albert H. Smith, whose experience and authority in such matters must be conceded.

Under all circumstances, except in certain abnormal positions of the child's head, the blades were to be applied with their long axes parallel with the occipito-mental diameter; and they had to be accurately opposed to one another in order to lock. Now, it seems to me, in the light of my own experience, that the difficulty of recrossing the handles ought not to be such as to render a special mechanism needful in order to avoid it. And I cannot but think that the deviation of the blades from parallelism, however brought about, involves danger.

When the mother's forces are inadequate to effect delivery, I think the time has come to use the forceps; and to obviate the necessity of a long-continued grasping of the handles, they may be tied together with a handkerchief, or with any other convenient band, as soon as the blades are accurately applied to the head. The compression so made is often necessary to the delivery; and on several occasions I have myself felt the bones of the head give way under the grasp of the instrument, but the mother was unharmed, and the children lived. As to forcible traction, I have heard of the child's head being torn off; I have several times seen a strong man brace himself with one foot against the bed, and apply his whole power to drag the child from the mother. In one case I have known this practice to result in the tearing away of part of the cervix, laceration of the vaginal wall, and permanent damage to the mother's local and general health. In the old style of forceps—and the Hodge pattern has always seemed to me the best—we had in each blade, used singly, a vectis; in one handle a blunt hook, an instrument often of great value; the other was a sharp hook, covered, when not in use, with a steel cap screwed on. Such a combination of instruments, which is very convenient in a practice involving long distances, cannot be, or at least is not, offered in the forceps presented by Dr. Stewart.

Dr. George E. Shoemaker: While this instrument is, no doubt, safe in Dr. Stewart's hands, it might not be so in those of others. That toggle-joint is a very powerful mechanical appliance, and the "shoulder" does not limit its action until the blades are quite close together. A moderately large head would not let them get so near together, and a very violent and harmful compression would result from even moderate traction upon the handle.

Dr. Stewart, in closing the discussion, said: In reply to the first speaker, among the original forceps as represented in the older works, were those with parallel blades, but I do not know of anything like this instrument. Of course, I do not claim all the credit of this invention, but share it with the instrument maker, who carried out my ideas. I was induced to have such an instrument made because of a number of complicated cases,

which came under my care, especially a difficult one in which I was called to assist a friend, who had been trying all night to get on the second blade of the forceps in a very narrow pelvis, where the child's head was jammed (in the right iliac region), and would not rotate. I advised using the second or female blade first, which we did with precaution in recrossing the handles, and the delivery was speedily effected. I am not anxious to use forceps or to make lacerations. My rule is not to apply instruments as long as there is any rebound to the labor.

There need be no fear of the toggle-joint permitting the blades to approach too closely, as the shoulder can be adjusted to any desired distance. It is new to me that a fœtus can be delivered without traction. If a wedge is all that is wanted, the toggle-joint is a better wedge than the cross-joint. The amount of compression is regulated by the necessities of the case. If the mother is left alone, she compresses the head of her child in her labor. In the cases (eight) where I used this instrument, I could not find a trace of its mark twenty-four hours after delivery. I would never use a handkerchief to tie the handle. I believe that in cases of contracted pelvis where other instruments could not deliver, this could. I had such an experience with a mannikin, in which the outlet was too narrow; failing with the cross handles I delivered with my instrument.

OBSTETRICAL SOCIETY OF PHILADELPHIA.

Thursday, March 1, 1888.

Thos. M. Drysdale, M. D., in the chair.

Dr. H. A. Kelly exhibited

An Aseptic Two-way Catheter.

A two-way catheter, which will conduct and discharge water and solutions with the utmost freedom, and at the same time allow of perfect and ready cleansing after use, is a great desideratum. In the light of the antiseptic surgery of to-day the use of such two-way catheters as were commonly found in the surgeon's bag a few years ago, is in the highest degree dangerous, owing to the necessarily painfully tedious process of cleansing, and the impossibility of ever being able to assure ourselves that they are clean. One of the best ever devised for the use of the gynæcologist is Bozeman's. This has been modified by Fritsch and Olshausen in such a way that the delivery-pipe and discharge-pipe are two separate pieces, so made that the delivery-pipe enters the larger discharge-pipe, and is held in place by a cap, which is screwed down on it while in use. This will be understood better in examining my modification. The objection to this still held, that although easier to clean than any previous forms, it was still difficult and impossible to assure one's self that it was clean. I have now added my own modification to this instrument, making it now perfect in its utility and answering all antiseptic requirements.

The syringe as constructed by me consists of three parts. First, the delivery-tube, which conducts the stream from the hose connected with the reservoir into the uterus. This tube is well curved, and at its entrance is furnished with a knob to hold the hose better. Its extremity ends in a button, with a series of holes around and a little below the outer margin, in the form of a rose, so placed that the stream is thrown out on all sides and directed a little backwards. The remaining two pieces are the two lateral halves of the *exit* pipe, which is attached very simply by entering each end in the shallow collar under this *rose*, bringing them together around the inlet pipe and screwing the nut down on the thread on their upper end. Each side has a fenestra in it, near the point, and is scooped out near its upper end, so that when the two are fitted together there is a good sized hole here.

When in use water flies with force from the holes at the end, washes with it *débris* and fluid, which enter at once the large fenestræ on the sides, are washed down and out of this large hole into the receptacle. When out of use the cap is unscrewed, the halves fall apart, and every part which has come in contact with infection is at once exposed and readily cleaned. The interior ought to be as highly polished as the exterior. Mr. Gemrig, of this city, has made these instruments for me in a very satisfactory manner. He has made one of solid silver for Dr. Sweetnam, of Canada, which I exhibit here with that I am now using, as well as the older form. If the nomenclature is to be kept up as in the past, it is the *Bozeman-Fritsch-Olshausen-Kelly* catheter.

Dr. Kelly also exhibited a

Cotton Packer.

This instrument has been many months on the shelf by my examining table, and is one of the few I am constantly using. I have showed it to a number of my friends, and at the meeting of the Alumni of the Woman's Hospital in New York, this winter.

Its use is simply to pick up a loose wad of cotton, placed near the vaginal outlet, and with the vagina properly exposed and the uterus redressed, to carry it up into place in the fornices, and pack in one wad after another with perfect exactitude and any degree of firmness required.

It is made of a delicately tapering needle, which balances nicely in the hand, terminating in three diverging tips, a little flattened on the upper and under surfaces.

Dr. B. C. Hirst exhibited

The Placenta from a Case of Unioval Twins.

It was very large in extent; having about twice the ordinary dimensions of a placenta. It formed one mass, with the most intimate anastomosis between the two sets of fœtal vessels. There was in this case hydramnion of one fœtal sac.

Dr. Hirst also showed

A Parietal Bone Presenting a Spoon-shaped Depression.

It had been taken from an infant which died about two days after birth. The labor had been a difficult one, terminated by the forceps; the child had presented by the vertex in R. O. P. position; the pelvis was slightly flattened, head large, O. F. circumference 36½ cm. At the corresponding point internally there was a deep broad depression of the brain substance. The child apparently died from congestion of and serous effusion into the brain.

Dr. Wm. Goodell remarked that Ambrose Paré had compared these depressions to the indentation on kettle-drums. The indentation in this case was very typical. After turning in the flat and narrow pelvis, these indentations were very marked. They occupied then the temporal region and not the parietal, the shorter bitemporal diameter being the one implicated. Hence in turning two mechanical advantages resulted, the small end of the cephalic wedge offered at the conjugate and also a cephalic diameter shorter than the biparietal.

Dr. John C. DaCosta wished to know if Dr. Goodell thought turning could always be done in these cases.

He spoke of a case which had occurred in his practice when the bone was much more depressed than in the specimen shown. The whole left side of the head was bulged in by a large fibroid of the uterus which fitted into the depression like a mortise and tenon joint. The pelvis was of good shape and roomy, os uteri wide open and soft, and yet the head which was at or above the superior strait, in L. O. A. position, would not descend on account of the tumor. As the woman was in good condition and nothing seemed to be going wrong he let her alone for a time. After a little while, by the aid of some manipulation the head began to unlock from the tumor and rotated from O. A. to O. P. position and the child was delivered alive. This case could not have been turned (as membranes had ruptured and uterus gripped the child's body itself) and even if it could have been, there would probably have been a dead baby from pressure on the cord during the long delay that would ensue in delivering the head, as the tumor would most likely have locked under the baby's chin. The forceps could not be put on, on account of obstruction to the left side by the tumor.

Dr. Goodell thought that Dr. DaCosta would have had less trouble if he could have turned the child. He did not think the neck would have been caught. He had been speaking before of the mechanical advantages only and not of the difficulties in the performance of version.

Dr. Longaker presented the following for Dr. Holmes:

The case of Mrs. B., 50 years old, married at 15 years, nulliparous, menstruation always scant and painful, is remarkable on account of series of reflex symptoms, of death from exhaustion and from pain, without organic disease other than ovarian, and of simplicity of operation needed as revealed by autopsy. Mrs. B. consulted me April, 1886, having been treated elsewhere for muscular rheumatism. Pains were of lancinating character along left sciatic, shooting down to ankle. Examination showed ovarian tumor, probably cystic. Prof. Goodell confirmed diagnosis and advised operation, which patient then and subsequently refused. The chief complaint was at first the pain posteriorly along left leg and thigh, which finally also involved similar relations on the right side. In the course of a few months, a persistent tremor attacked both lower extremeties, at first alleviated by manual pressure, subsequently not, and later still extended to arms and hands, and later yet to muscles of face and lips, giving much the appearance of violent chorea, interfering markedly with clear enunciation. During the latter part of life there was oft repeated and painful micturition, with bloody urine, with violent pains starting in lumbar region and shooting along into the bladder and urethra, raising a strong suspicion of renal calculus. This with the other lancinating pains, the tremors and nervous exhaustion consequent upon the many months illness, caused great suffering, the patient often wring-

ing her hands and grasping her hair in agony. Hypodermics of morphine, one-quarter to one-half grain, gave markedly greater relief than same doses by mouth or rectum, even frequently repeated. The apparent increase of tumor was very slow. Autopsy indicated only slight omental adhesions; kidneys healthy. The bladder, uterus, and the two attached cysts, were removed a few hours after death. The dermoid cyst has a long, slender pedicle, attached to the left cornus uteri. It was situated on the right side of the spinal column, opposite the third and fourth lumbar vertebræ, covered by loops of small intestine and by omentum, to which latter it was slightly adherent. It was at first supposed to be a floating kidney, which had undergone conversion into a cyst. Its size, shape, and location, were suggestive of such an origin. The cyst contained chocolate colored sebaceous matter. No hair or teeth. The wall contained calcareous plates. The right ovary is the seat of a multilocular cyst, the size of an average full term fœtal head. The corpus uteri is undeveloped, the cervix constituting the larger portion of the organ. Evidences of chronic cystitis were present.

Dr. M. Price said that this question was coming up daily; cases of pelvic disease were being constantly treated by the general practitioner for malaria, rheumatism, neuralgia, and other kindred diseases, without making any investigation into the actual condition of the patient. In fact, malaria is becoming extremely fashionable, when there is no apparent reason for the condition. He was then treating a case of ovarian disease in a lady now 47 years old, who was married at 15 years, contracted gonorrhœa from her husband at that time, has ever since remained sterile, with scant menstrual discharge, and great pain from the approaches of her husband the pain sometimes being agonizing. She suffers at times from severe pain running down the left leg. Upon examination the ovary was found to be as large as an orange, excessively tender, and when pressure was made in bimanual examination the patient went into convulsions on the table. He did not know what relation this condition may have had in connection to the trouble in her early married life; but of this he was sure, that it was the cause of her barren condition.

Dr. Longaker also exhibited

The Post-mortem Specimens from a case of Carcinoma Uteri.

The following brief notes of this case are presented for Dr. J. S. Gibbs. L. A., married, 39 years old. Always enjoyed good health until five years ago, when her last child was born, since that time she had suffered much from pelvic pains. Menstruation had been excessive. Patient first seen in June, 1887, when a diagnosis of carcinoma of the cervix was made. The disease had invaded the vaginal walls, and the pelvic cellular tissue. From this date I saw no more of the case until Feb. 6, 1888. She had been free from pain, but hemorrhage persisted. Vaginal examination revealed advance of the disease. It provoked such a profuse hemorrhage that application of Monsell's solution was required to arrest it. When the hemorrhage was under control, pledgets of cotton saturated with terebene and olive oil (1–4) were packed against the cervix according to the plan of Betrin, of Geneva. This medication diminished the offensive odor, but I strongly suspect it had something to do with the rather untimely demise of the patient. In a few hours from the time of the application she sank into a somnolent state from which it was difficult to arouse her, with almost complete suppression of urine and strangury, and death in 36 hours.

A peculiarity of the case was absence of cachexia and emaciation.

Autopsy.—The cervix was extensively infiltrated and ulcerated. The corpus shows a few nodules. The ureters are dilated as are also the pelves of the kidneys.

Dr. G. E. Shoemaker thought that the statement that death was probably due to an application of terebene should be carefully considered. He was constantly using, and observing the use of the drug internally in much larger quantities than could be absorbed from such an application, without a sign of irritation. Might not the death from uræmia have occurred independent of its use?

Dr. Longaker believed that the application terebene did hasten death. The strangury and suppression came on quickly after it had been used. The case lacked some of the ordinary symtoms of uræmia.

Dr. Wm. Goodell exhibited a

Specimen of Conjoined Twins,

which had been presented to him by Dr. Junius F. Fuller, of Roxborough, N. C. The specimen was a perfect one—the bodies were united at the hips and there were three feet in common. Some years ago an analogous living specimen of conjoined twins was on exhibition in this city, and he had brought them before his class at the University, and had given a lecture upon the subject. From investigations then made he found that this form of conjoined twins was not a very rare one,

as Aldrovanus and other old writers had described and figured them. The specimen which he presented must have been aborted at the third month of utero-gestation.

Dr. Goodell also presented a

Specimen of hydro-salpinx.

It was the largest specimen he had ever seen; although he had met with much larger specimens of pyo-salpinx. The case had been treated by many gynæcologists and the true condition had not been recognized. There had followed the operation a complete relief from pelvic pains, but menstruation had continued up to the present time. The periods were, however, becoming less frequent. Since it was contended by some eminent surgeons, that when menstruation continued after the removal of the uterine appendages, some of the ovarian stroma must have been left behind, he wished to call the attention of the Society to the complete extirpation in this case of both ovaries and tubes. Although the former were more or less adherent, it was evident from the specimens that not a particle of ovarian stroma was left behind.

Dr. M. Price said he had seen two cases in his practice where the menstrual discharge did not cease after the removal of the appendages. In one case it lasted for a year and a half, in the other six months. He had no doubt but Dr. Goodell's case would show the same result. There was but little doubt in the mind of most operators that the removal had not been complete.

Dr. W. H. H. Githens, who resigned the Secretaryship of the Philadelphia Obstetrical Society the first of the year, after an uninterrupted service of eleven years, was presented this evening, in the name of the Society, with a very handsome mantel set (including clock and side ornaments) in recognition of the very valuable services he had rendered the Society during his long term in office.

Officers of the Philadelphia Obstetrical Society for the ensuing year: *President*, Thos. M. Drysdale, M.D.; *Vice-Presidents*, Chas. H. Thomas, M.D., J. C. DaCosta, M.D.; *Secretary*, J. M. Baldy, M.D.; *Treasurer*, Alfred Whelen, M.D.; *Curator*, T. Hewson Bradford, M.D.

The *Allgemeine med. Central-Zeitung* says that Prof. Ball obtains successful results in acute vaginitis from suppositories of oil of copaiba and cocoa butter, each one drachm; and opium one-half grain. These may be allowed to stay in the vagina for twelve hours.

Periscope.

Antifebrin in Feverish Conditions in Childhood.

This paper, by J. Wedervitz (*Wiener med. Wochenschr.*, Nos. 17, 18, 1887), records fifty-three cases, including scarlatina, measles, simple and with pneumonia, erysipelas, croupous pneumonia, etc., which were treated with antifebrin. Two noticeable points, not previously observed, were brought out.

First, that the effect of the drug was seen within from ten to twenty minutes after it was taken, and the fall of temperature was very rapid till it reached its lowest point, when it began slowly to rise again, the rapidity of the fall depending more on the individual and the disease than on the dose given. The second point was the surprisingly favorable influence of the antifebrin on the general condition of the children. In almost every case restlessness was overcome, and sleep followed within a quarter of an hour after the dose was taken. Of the various diseases under treatment scarlet fever and erysipelas were the least affected by the drug; measles and pneumonia responded more certainly, and tubercular affections complicated with measles most quickly of all. The pulse was not affected to the same extent as the temperature. The dose given was about two grains to children three or four years old, and four to five grains to older children. The smaller doses, as a rule, were sufficient in the badly nourished, who as a rule react more energetically to the drug. As much as 30 grains was occasionally administered daily. Antifebrin had no noteworthy effect on the general course of the disease.—*Edinburgh Med. Journal*, December, 1887.

Uses of Cannabis Indica.

In *The Practitioner* of February, 1888, Surgeon-Major J. F. P. McConnell, of the Bengal Service, in an article on this subject, calls attention to some uses of cannabis indica which do not seem to be as well-known as they deserve to be. The contradictory results obtained by different men he thinks is entirely attributable to the difficulty in obtaining fresh preparations of the plant; for the resin—the so-called *Cannabin*—upon which the properties of the Indian hemp depend, certainly deteriorates by keeping or storage. When care is taken in this respect the therapeutic value of the drug in certain affections of the nervous system—tetanus, neuralgia, migraine, etc.—and its powerful

effect in controlling uterine hemorrhage, has been repeatedly recorded by competent observers, and its employment for the relief of such affections is well understood and frequently resorted to. In the present paper, however, he speaks especially of three conditions. One of these conditions is *anorexia*—loss of appetite consequent upon exhausting diseases, such as prolonged fevers, diarrhœa, dysentery, phthisis, etc. There is a repugnance to and intolerance of food in almost every form, which do not always yield to acids, bitters, and nux vomica as usually given. In such cases cannabis in small doses (♏ v–x of the tincture, or gr. ¼–½ of the extract) have been found very useful. The tincture may be given in emulsion, with a small quantity of mucilage and simple syrup, and flavored with rose-water. The extract may be given in lozenge or bonbon form, after being rubbed up with white sugar, gum acacia, etc., to proper consistency. The mixture or lozenge may be given three times a day, half an hour before meals, and will frequently in two or three days bring back appetite for food and promote its digestion. Both these preparations are very palatable and readily taken by even fastidious patients.

A second condition is *dyspeptic diarrhœa*, and the diarrhœa that is associated with defective action of the liver and deficient secretion of bile, which tends to diarrhœa alba (tropical diarrhœa), in which there is a tendency to action of the bowels soon after meals, and a consequent hurrying of imperfectly digested food through the bowels, accompanied with active vermicular movements of the latter, with much flatulency, borborygmi, etc. In the earlier stages of this disease cannabis is often of great service in controlling the diarrhœa. Even in more advanced stages of tropical diarrhœa cannabis is sometimes useful. The disease seems to be one primarily and essentially of the liver, and cholagogue remedies must be used. Of these mercury is most reliable—as blue pill or gray powder. The mercury is given at night, and the cannabis during the day. He begins with ♏ x of the tincture, and gradually increases the dose to ♏ xv, xx, or xxx, three times a day or oftener. A suitable combination is:

Tincture of cannabis indica	♍ x–xx
Subnitrate of bismuth	gr. x
Mucilage of acacia	℥ss
Comp. spirit. of chloroform	♍ xx
Cinnamon or peppermint water	f℥j

Give before or after food, preferably after, especially when the dose is increased, since in this way unpleasant symptoms, such as headache, giddiness, hallucinations, etc., are obviated. Both in tropical and in dyspeptic diarrhœa cannabis is better than opium, because it in no way interferes with the bile-forming function of the liver. But when tropical diarrhœa has gone so far that the functional disorder of the liver is succeeded by organic changes, cannabis is useless.

A third condition in which cannabis is useful is in cases of chronic cardiac disease, and in chronic Bright's disease as a *hypnotic*. In cases of distressing insomnia and general inquietude, with an enfeebled heart, in which chloral seems inadmissible, the administration at bedtime of ♏ xv–xx of tincture of cannabis, with a small dose of chloral (gr. x) and ℥ss of bromide, will often give the desired effect. He has assured himself by check experiments that this good hypnotic effect is not to be attributed to the chloral and bromide, but to the cannabis indica.

Rare Case of Lead Poisoning.

At a meeting of the Medico-Chirurgical Society of Edinburgh, November 2, 1887, Dr. Byrom Bramwell showed a man suffering from peculiar symptoms, the result of lead-poisoning. The patient had presented himself at the Infirmary a fortnight before, complaining of dimness of vision, severe headache, and tremor affecting especially the right hand, but distributed generally over the body. The acuteness of vision was found on examination to be reduced to less than one-tenth, and the fields very much restricted. Greens and blues could not be distinguished, and the color fields were much reduced. There was no optic neuritis. The fundus was, in fact, perfectly normal—a very interesting, and, so far as Dr. Bramwell knew, a very rare condition in cases of lead blindness. Under large doses of iodide of potash, and sulphate of magnesia purgatives, the headache had disappeared, and vision was now normal.—*Edinburgh Medical Journal*, Feb., 1888.

Treatment of Articular Rheumatism.

Aufrecht (*Deutsche med. Wochenschrift*, January 12, 1888) has had an interesting experience in the treatment of rheumatism. As the result of extensive trials he came to use salicylic acid in acute cases to the exclusion of all other remedies, and with complete success so far as the disease was concerned. He used the acid in full doses, ninety grains a day for the first two or three days, and

sixty to forty-five grains during the following eight or ten days. Unfortunately, this treatment could not be fully carried out in every case. Burning pain in the stomach, vomiting, tinnitus aurium, or dyspnœa, sometimes made the drug unbearable. The use of salicylate of soda in corresponding doses was no improvement. Not only did it cause the same disagreeable symptoms as the acid, but in Aufrecht's hands was not as effective in subduing pain and fever. On the introduction of salol, a trial of it showed a marked improvement in many respects. Causing but little local or general disturbance, its use could be continued almost indefinitely. Thus, one patient took altogether more than 3,500 grains in doses of ninety grains daily. On the other hand, in acute polyarthritic cases, it was not so effective as salicylic acid. Whereas the latter usually subdues pain and fever in the first twenty-four hours, salol requires three or four days, though pain was greatly ameliorated within the shorter period. In consequence of its many advantages salol was adopted as the routine treatment by Aufrecht, but on the occurrence of a fatal case of acute endocarditis under its use—a thing not met with among six hundred cases treated with salicylic acid—it was discontinued. Since then what might be called the mixed treatment has been followed. In this, acute cases receive during each of the first two days ninety grains of the acid, and after that the same amount of salol. Later, the patient still remaining in bed, the salol is reduced to sixty grains daily. As salicylic acid is usually well borne for two days, but frequently no longer, this recommends itself as the best routine treatment. If possible, the acid may be continued; if, on the otherhand, it cannot be taken, salol may be used. In chronic articular rheumatism salol is preferable in every respect, not only avoiding the dangers attending prolonged use of salicylic acid, but offering more positive assurance of cure.—*American Journal of the Medical Sciences*, March, 1888.

Creasote in Phthisis.

According to the *Lancet*, January 28, 1888, Dr. V. T. Bushuyeff has recently reported in *Vrach* the results obtained by treating cases of phthisis with creasote in Prof. Koshlakoff's clinic in St. Petersburg. The quantity of creasote given was usually about three drops during the twenty-four hours. The number of cases so treated was 20, and the duration of treatment from one to six months. Of these 20 cases, 10 were in the first stage, 6 in the second, and 4 in the third. In all the cases in the first stage the treatment was followed by a marked improvement. Four out of the 6 in the second stage were benefitted, but none of those in the third stage. In five of the cases in the first stage it may almost be said that the creasote produced a cure, because the dulness and bronchial respiration, as well as the râles, ceased. In only one patient did the creasote produce any undesirable effects, and this patient, who was in the last stage of the disease, took six drops (instead of three), for three days. The result was acute nephritis with anasarca. The drug may be given in wine, glycerine, cod-liver oil, and in capsules or pills.

Dislocation of the Head of the Femur on to the Pubes.

At the meeting of the Sheffield Medico-Chirurgical Society December 8, 1887, Mr. Pye-Smith (*Lancet*, January 14, 1888) reported the case of a man, 56 years old, who became overbalanced in walking round a low wall in the dark, and fell backwards, dislocating the left hip. He was brought to the Sheffield Public Hospital and Dispensary late the next day. The injured limb lay straight by the side of its fellow, but the foot and knee were everted almost to a right angle. The head of the femur was easily seen and felt beneath Poupart's ligament, just external to the femoral artery, which was slightly displaced inwards. The two thighs measured precisely the same from the anterior superior spine of the ilium to the adductor tubercle of the femur, but the right leg was an inch shorter than the left owing to an old fracture above the ankle. Bryant's line was also equal on the two sides, but the great trochanter was a quarter of an inch nearer the middle line of the body on the injured side than the sound side. Reduction was effected twenty-two hours after the accident by traction in the axis of the limb in a slightly over-extended position, combined with rotation inwards.

An herpetiform Affection of the Tongue.

Fournier reports to *La Semaine Médicale* upon an affection of the tongue which appears, not rarely, several years after an attack of syphilis which has been seemingly well cured. It appears in erosions, especially on the margins of the tongue, which are marked by great resistance to anti-syphilitic treatment, as well as by great capacity to repeat themselves after cauterization, and similar methods of treatment. He identifies these lesions with those of "relapsing herpes of the genitals" of Doyon—a very obstinate form of herpes of the genitalia, occurring

after syphilis. His opinion is based upon the following facts: 1. The affection appears only in the form of quite superficial erosions, affecting the mucous membrane. 2. The erosions are small, averaging from the size of a lentil to that of a grain of wheat, but sometimes scarcely the size of a pin. 3. The erosions are numerous and scattered; they are found with especial frequency on the margins of the tongue, but are also present on the back of the tongue. 4. They are ephemeral, like herpes; if let alone they last about eight to fourteen days, provided that no specially unfavorable influence is at work, such as tobacco smoking, or bad condition of the mucous membrane of the mouth. 5. The extraordinary propensity to relapse is in favor of herpes, especially the relapsing form of the latter disease. 6. Finally, the herpetic character of the polycyclic configuration of the erosions is pronounced.

Herpes presents itself ordinarily as a group of blisters, which grow peripherally, and coalescing burst, leaving behind an eroded surface, which also exhibits the polycyclic form. Only one affection shows a similar configuration of superficial lesions, namely, the vulvar, perivulvar and perianal syphilide; but in this latter the circles are single, and the indentations considerably larger. As regards the color of these erosions of the tongue, they seem somewhat red, and before the epithelium is stripped off, more grayish. They cannot be taken for blisters, on account of their ephemeral character. The author believes their return is brought about by the immediate use of mercury, tobacco, etc. For this reason a mercurial treatment aggravates the disease. He regards the affection as non-syphilitic. — *Deutsche Medizinal-Zeitung*, Dec. 15, 1887.

Catarrh of the Antrum.

In cases of catarrh of the antrum, Dr. Schiffers, of Liège, instead of extracting the second molar, gains access to the cavity through the opening in the middle meatus of the nose. Through this he inserts a director, and with the help of a curved, probe-pointed bistoury, he opens up a passage for the free exit of the confined secretion. By the use of cocaine, the patient suffers but little during the operation. Dr. Schiffers points out that catarrh of the antrum is frequently overlooked and mistaken for an affection of the mucous membrane of the nose. When an abundant fetid discharge runs from the nose, especially when it is intermittent, the existence of disease of the antrum should be suspected. A careful search should then be made, with the help of the nasal speculum and a good light, for the welling up of the secretion through the foramen in the middle meatus.—*Lancet*, Dec. 31, 1887.

Vaccination in England.

The *British Medical Journal* in its summary with regard to vaccination for the year 1887, says: No notable event concerning vaccination has been recorded during the year. Arm-to-arm vaccination has been carried on at all the stations except that of the Local Government Board at Lamb's Conduit Street, where the practice is to vaccinate from the calf; here the demands for vaccination have steadily grown, and we learn that the number of applicants is now so great that the Board have to face either a limitation of the usefulness of the institution, or its relief by the opening of a similar station in another part of the metropolis.

With regard to vaccination of children, Dr. Stevens has shown for London that the protection of children is increasing, and that the alleged deaths from small-pox in early life after vaccination become enormously reduced when the true facts are known. Thus, of 116 children under 15 years of age stated to have died of small-pox after vaccination, there were only two on whose history of vaccination he could rely, and of 24 deaths in children under 5 years of age in which the vaccination was entered as doubtful, he found that 11 had not been vaccinated at all, and 6 had been vaccinated during the period of incubation of small-pox, and therefore too late to be protected.

Tamponing the Uterus with Iodoform Gauze.

Two papers have recently been presented on this subject. One is by Dr. A. Dührssen, of Berlin (*Centralblatt für Gynäkologie*, No. 35, 1887); the other by Dr. F. Fraipont, of Liège (*Les annales de la société méd.-chirurg. de Liège*). Both these authors recommend the tamponing of the uterus with iodoform gauze in atony of the uterus after premature birth and birth at full time, in case the ordinary hemostatics—injections of ergotin, manipulation of the uterus and hot douches—do not accomplish the desired object. It is asserted that these tampons are at the same time disinfectant. The strips of gauze may be removed after twenty-four hours, but may even remain two to three days without a sign of decomposition in the cavity of the uterus occurring.

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CHEERFULNESS AS AN AID TO MEDICINE.

There are few characteristics which go further toward making a successful physician than a judicious cheerfulness, which, while it does not underrate the importance of human ills, does not overrate them either. The bright, sunny disposition of certain medical men does as much good as their medicines. This is the doctor's contribution toward the cure or alleviation of disease. But there is something of the same sort which may be contributed by the patient, and his friends. Both he and they may do much to supplement the labors of the physician by maintaining as much as possible a cheerful frame of mind. We have all heard, indeed, of patients so hopeful that they insisted they would get well, when the doctor said they would die—and did it, too. Of course no physician could approve of such insubordination; but we are all willing to have our patients help us by making a good, brave, cheerful fight for recovery as long as there is a fighting chance. Unfortunately there are times when low spirits or bad judgment put great obstacles in the way of a patient's recovery. An illustration of this is recorded in the *Monthly Bulletin of the Iowa State Board of Health* for January, 1888. In the case referred to, a woman with consumption, who was a mother, sat for much of her time in a room on the walls of which hung two mottoes: "What is home without a mother?" and "There is sweet rest in heaven." The editor of the *Bulletin* very properly suggests, that the frame of mind produced by contemplating these mottoes—however excellent they may be in themselves—could hardly fail to be prejudicial to the case of the mother in question.

No right-minded medical man would seek to restrain the tender sentiments of his patients, or to interfere with the comforts of a religious hope; but no more can any sensible medical man doubt that both of these, indulged in an unwise way and dwelt upon at unfit times, may do much harm. For this reason medical men may well look to the surroundings of their patients' minds as well as to those of their bodies, and do all that they can to prevent the mischief which may be caused by gloomy reflections, or morbid longings. It is no small part of his office to remove such influences judiciously and considerately; as it is no small part of the duty of his patient to consent to their removal, and to cultivate a hopeful and cheerful frame of mind. This is the only wise and right way; and it is as justifiable from the standpoint of the moralist as from that of the physician.

THE PRAISE OF COUNTRY PHYSICANS.

Medical men who reside in the cities, and are surrounded with all the conveniences which are found there, have often only imperfect ideas of the hardships which are borne by physicians who practice in the country. To such persons we would heartily commend an effort to learn what their country brethren go though in their labor of humanity, in order that they may appreciate as they should the work which the latter do. If this were fully understood the city physican would think more highly of his brother of the country, and would probably feel that

the brilliant achievements of the great medical centres by no means eclipse the worthy services and noble sacrifices of the country districts. For downright heroic work no men in the medical profession can compare with those who press over dangerous roads or through swollen and icy streams, by day and night, in their errands of mercy to the sick and injured.

These reflections are prompted by reading in the Williamsport *Weekly Sun and Banner*, Feb. 23, 1888, a sketch of the experiences of Dr. Thomas Lyon, who for more than fifty years has practiced medicine in and about Williamsport, Pa., and who still lives to enjoy the esteem which such a long career of usefulness must bring. The narrative of this career is so interesting that we wish we had space in which to place it all before our readers. It would, we are sure, excite a warm glow of sympathy in many a heart, and a feeling of admiration in others whose experiences have been too easy to permit them to fully sympathize with it. But to all alike, we think, the thought would come that our country may well be proud of a set of men to whom such experiences, such sacrifices, such achievements are no rare things; and it would encourage anew the thousands of faithful, earnest men all over our land who fill the important and honorable post of country physicians.

TREATMENT OF INFANTILE DIARRHŒA.

Sometime ago, HAYEM, of Paris, announced that he had obtained excellent results in the treatment of the diarrhœa of little children, characterized by the passage of green stools, with a solution of lactic acid. At the meeting of the Société Médicale des Hôpitaux, on January 13, he reported the result of further experimentation with this simple remedy, and his increased confidence in it. His former announcement is modified, in that he advocates the use of larger doses *per diem*. He now uses a two per cent. solution in water, sweetened with cane sugar, and gives of this from twelve to twenty coffee-spoonfuls a day; that is about a half-teaspoonful at a dose, every half hour, except at nursing times. One of the good effects of this remedy is that it puts a stop to the vomiting, which is often so obstinate in these cases.

Hayem has used lactic acid, also, in some cases of chronic diarrhœa in adults. In the greater number of cases of entero-colitis, or of chronic intestinal irritation due to an improper regimen, and accompanied by gastric dyspepsia, the administration of lactic acid has brought about a rapid cure. To adults, Hayem gives three tablespoonfuls of a two per cent. solution daily.

At the same meeting M. Sevestre confirmed the opinions of Hayem. He, however, gives more of the remedy, administering a coffee-spoonful every five or ten minutes in severe cases. In some cases of bilious diarrhœa which resist this method, Sevestre has had good results from the use of large doses of bicarbonate of soda, namely about ten grains for each pound of the weight of the child.

These facts encourage the belief that lactic acid is a valuable addition to the number of remedies applicable to the treatment of the diarrhœa of infants and little children. In considering the treatment of the diarrhœa of of infants, however, it is well to bear in mind a point to which ESCHERICH, of Munich, has recently called attention (*Jahrbuch f. Kinderheilkunde*, 1887), namely, that the persistence of diarrhœa is often dependent upon persistence in the use of improper food. And it appears that certain forms of diarrhœa are dependent upon decomposition of certain kinds of food. In a mixture of albuminous food with hydrocarbons, the latter appear to undergo decomposition first. An example of this is seen in milk, in which the acid fermentation precedes the decomposition of the albuminoids. For this reason it seems rational to use albumen-water in cases of diarrhœa dependent upon decomposition in the upper part of the intestinal tract, and accompanied by acid stools. On the other hand, a diarrhœa marked by fetor, and the signs of decomposition of the albuminoids, with alkaline stools, requires a withdrawal of the latter from the food and the use of hydro-

carbons alone; and such a course often leads to rapid recovery.

This view of the causation of infantile enteritis has a very important bearing upon the use of the remedies mentioned above, namely, lactic acid and bicarbonate of soda, and may aid very decidedly in determining the choice between them. More than this, a proper recognition of the significance of acid or alkaline stools may obviate the necessity for using either of these remedies, if it leads to a correction of the diet, and thus to recovery.

THE REPORTER AND "READING NOTICES."

Ever since the MEDICAL AND SURGICAL REPORTER passed from under the control of its former editor, it has pursued the policy of rigidly excluding from its columns of reading matter the puffs of advertisers, which are known as "reading notices." These are much desired by advertisers, and we believe advertising contracts are often made under an expressed or implied promise that "reading notices" shall be given in addition to the space regularly paid for. Observant readers of medical journals must have remarked that there are but few which keep their advertisers strictly to the advertising pages. The few that do this sometimes lose tempting opportunities to make money; and it cannot but be painful for them if they both lose the money and miss the reputation which they are trying to secure. This is the case in which we now find ourselves; for we see in the columns of some of our contemporaries, notices of wares credited to the MEDICAL AND SURGICAL REPORTER, which we have no knowledge of, and which could not be published now in the reading pages of this journal for any price. So we beg our readers to take notice of the rule we have adopted, and to which we have adhered—that no "reading notices" are ever published in the REPORTER; and we ask our contemporaries to do us the favor of refusing to admit to their columns what might place this journal in a false light. We will do all we can to aid our fellow editors in getting rid of the nuisance of so-called "reading notices," and if they join us, the time may come when no medical journal need tremble, no matter what pressure is brought to bear on it, by those who have no special interest in the tone of medical journalism.

THE AFTER TREATMENT OF TRACHEOTOMY.

In the *Deutsche med. Wochenschrift*, February 16, 1888, DR. KARL ROSER, of Marburg, refers to the statistics collected by Drs. Lovett and Munro, and published in the *American Journal of the Medical Sciences*, July, 1887, in which the death ratio was shown to be seventy-two per cent. in a total of 21,853 operations of tracheotomy. This mortality is much higher than that which has prevailed in the hospital at Marburg during the last three years and a half, in which forty-seven such operations were performed with only forty-seven per cent. of deaths. This satisfactory result Roser attributes to the use of a modification of the ordinary tracheotomy canula, which he devised. This modification consists simply in wrapping round the canula a strip of gauze moistened in a sublimate solution, about two-thirds of an inch wide and three inches long, and rubbing powdered iodoform into it while yet moist. When it dries the gauze forms a smooth hard envelope surrounding the canula, and extending from near its extremity to the guard. When the tube, thus covered with iodoform gauze, is inserted into the trachea, it absorbs moisture, becomes soft, and completely fills the lumen. The result is to prevent the descent of irritating or infectious materials from above the canula, and to render aseptic the portion of the trachea with which it is in contact.

The custom at Marburg is to leave the first canula in place for at least two days, and then to substitute for it another, prepared in a like manner. After five days it is believed that there is no longer danger of secondary infection of the trachea, and no specially prepared canula is needed; in fact no canula is needed if the larynx is clear. Roser believes that this method of modifying the ordinary tracheotomy tube is of service even when the trachea is already implicated in a diphtheritic process.

The advantages already mentioned are not all that are claimed by Roser for what he calls the "iodoform tampon canula;" but they seem to justify his favorable opinion of it, and they may partly account for the good results which have followed the operation of tracheotomy at Marburg. It certainly seems worth while for American surgeons to know what it seems to have accomplished, and to take into consideration the propriety of testing its merits for themselves.

Book Reviews.

[Any book reviewed in these columns may be obtained, upon receipt of price, from the office of the Reporter.]

PHYSICAL CULTURE FOR HOME AND SCHOOL, SCIENTIFIC AND PRACTICAL. By Prof. D. L. Dowd, of the Home School for Physical Culture of New York. With 80 illustrations. Small 8vo, pp. xxii, 300. New York: Fowler & Wells Co., 1887. Price, $1.50.

This book is one of the most interesting works on physical culture which we have ever seen. The author is a man who, by the methods he describes, has developed his frame from that of a narrow-chested, almost consumptive-looking individual to that of an athlete. But he does not regard the mere cultivation of muscular strength as the proper end of physical exercise. He takes the sensible and correct view that the object of judicious exercise must be to develop the whole of the body symmetrically, and to improve its tone rather than its bulk. The method he recommends is founded upon accurate anatomical knowledge, and brings into action all the muscles, sometimes singly and sometimes in groups.

As a book of instruction this work leaves little to be desired, and one of its greatest merits depends upon the fact that it calls for but little apparatus, and for none which is not within the reach of everybody. We can recommend it heartily to our readers, especially as we believe that its advice to persons afflicted with moderate deformities of the legs or spine is sound and worthy of acceptance. To school-teachers, without the aid of a trained educator in physical development, the book will prove of especial value.

A MANUAL OF PHYSIOLOGY. A Text-Book for Students of Medicine. By Gerald F. Yeo, M.D., Dubl., F.R.C.S., formerly Professor of Physiology in King's College, London, etc. Third American from the second English edition. 8vo, pp. 758. Philadelphia: P. Blakiston, Son & Co., 1888. Price, $3 00.

This is a book whose modest title hardly does justice to its contents. It is indeed a manual, and no doubt one of great value for students of medicine. But in addition to this it is so thorough, though condensed, that it must prove of great service to any practitioner. It lacks some of the details which are usually included nowadays in more pretentious treatises on physiology; but what it does discuss is discussed so clearly, so succinctly, and so soundly that it is peculiarly adapted to the needs of busy men. It contains three hundred and twenty-one illustrations, which worthily supplement the text, and is handsomely printed and bound. We can heartily recommend it to our readers as the best succinct work on physiology with which we are acquainted.

DISEASES OF THE HEART AND CIRCULATION IN INFANCY AND ADOLESCENCE. By John M. Keating, M.D., Obstetrician to the Philadelphia Hospital, and Lecturer on Diseases of Women and Children, etc., and William A. Edwards, M.D., Instructor in Clinical Medicine and Physician to the Medical Dispensary in the University of Pennsylvania, etc. Large 8vo, pp. 215. Philadelphia: P. Blakiston, Son & Co., 1888.

This work has been published in monthly instalments in the *Archives of Pediatrics*, during the year 1887, and is now presented to the medical profession in the more convenient shape of a book. It is a very handsome volume, illustrated with wood-cuts and two photographs. It contains an admirable summary of the literature of its subject, supplemented by the facts and opinions gathered from the observations of the authors. It discusses fully the phenomena of the diseases of the heart and disturbances of the circulation in regard to their nature, mechanism, causation, natural history and treatment. We do not know of any book in which these matters are so fully discussed, especially as they concern infants and children, and Dr. Keating and Edwards have done the profession good service in presenting them in such a clear and practical way.

THE THREE ETHICAL CODES. 7½ x 4½ inches, pp. 55. Detroit, Mich.: The Illustrated Journal Co. Price, 50 cents.

This little book contains the Code of Ethics and the Constitution and By-Laws of the American Medical Association, the Code of Ethics of the American Institute of Homœopathy, and the Code of Ethics of the National Eclectic Medical Society. Of the three Codes, that of the American Medical Association is the longest, and that of the Eclectic Society is the shortest, while much of the Homœopathic is similar to that of the first named. It is a handy little book for reference, as occasion may require.

Pamphlet Notices.

Four Months Among the Surgeons of Europe. By N. Senn, M.D., Ph. D., Milwaukee, Wis. From the *Journal of the American Medical Association*. 162 pp.

The Nature of Contagion. By J. W. McLaughlin, M.D., Austin, Texas. From *Daniel's Texas Medical Journal*. 8 pp.

Agnosticism, Based on Physical Science. Second (revised) edition. By Alex. W. Stein, M.D., New York. 1888. 20 pp.

Elixir Paraldehyde: The Coming Remedy, as a Substitute for Opiates and Anodynes. By A. B. Cook, A.M., M.D., Louisville, Ky. From *Progress*, January, 1888. 4 pp.

—Dr. Senn's little book contains a series of letters written by him to Dr. Chr. Fenger, of Chicago, and published last year in the *Journal of the American Medical Association*. They are extremely interesting as giving the impressions made upon a careful observer by the medical men and medical institutions

of Europe. Everywhere Dr. Senn went he was received courteously, and enjoyed the hospitality which an intelligent American is sure to receive. Those who have had the pleasure of experiencing this hospitality cannot fail to enjoy Dr. Senn's description of his experiences; and those who have not had this pleasure may learn much that is interesting and gratifying from what he relates, and can make a sort of acquaintance with men of well-known names, whose writings they are already familiar with.

—Dr. McLaughlin's pamphlet contains the substance of his remarks upon two papers read at a recent meeting of the Austin District Medical Society, one on Septic Fever and the other on Typhoid Fever. It describes in an intelligent way the modern theory of contagion, which holds that this is due to specific micro-organisms and their products.

—The title of Dr. Stein's pamphlet is misleading; for his address contains an argument which, starting with a description of the limitations of human knowledge, leads up to an expression of faith in immortality as expressed in the language of Socrates and of St. Paul. One who holds to a religious faith may shrink a little at the first part of this pamphlet; but he will certainly be comforted when he finds how clearly Dr. Stein makes the distinction, too seldom made, between confessing ignorance, and denying. Man may not know he is immortal; but no more does he know anything positively of the material and phenomena of this life; and it is no violent straining of logic to assert that if matter, of which we know so little, is indestructible, so may consciousness, of which we know but little, be also indestructible.

—Dr. Cook has a very high opinion of the value of paraldehyde, which is undoubtedly a very useful hypnotic. Its objectionable taste, he says, is well disguised in an elixir which the Louisville druggists prepare. The dose of paraldehyde in this Elixir is from forty-five minims to a fluid drachm and a-half to the ounce, and Dr. Cook has found that excellent results are produced by the use of tablespoonful doses of the compound.

Correspondence.

Antipyrin in Pleuro-pneumonia.

Editor Med. and Surg. Reporter:

Sir:—I send a brief report of a case which I would like to see published in the Reporter.

On February 3, I was called to see Mr. S——, about 34 years old, and found him suffering with pleuro-pneumonia of the left side. This was his third attack, the former ones, occurring four and eight years ago respectively. As he was given to alcoholic excesses, I was a little doubtful of his recovery, especially as the case was a grave one and pointed to speedy dissolution. After the ninth day, there was marked improvement, for which I am indebted—under Divine Providence—to that newly-discovered, wonderful medicine "Antipyrin," which I think, gives promise of great usefulness, especially in cases of this character.

I hope some brother physician will give this drug a trial, and obtain as good results.

Yours truly, Joseph Hopson, M.D.

St. Matthews, Ky.

Feb. 29, 1888.

Advice wanted for Tinnitus Aurium.

Editor Med. and Surg. Reporter:

Sir:—I would be glad to have advice from the readers of the Reporter as to the treatment of the following case:

Mrs. E. C., 49 years old, married, a healthy, robust looking woman, weighing about 160 or 170 pounds, has passed the menopause with little trouble. She is the mother of one child. She applied to me for treatment in July, 1887, complaining of violent periodical tinnitus aurium: noise in both ears, sometimes musical, at others roaring, whistling, hissing, etc., with fulness and throbbing of head. Sleep relieves her, but is often prevented by the tinnitus, which worries and annoys the patient greatly. She is a woman of active habit, and often tries to "work off" these spells, but is not always successful. She cannot tell when the spells will come on. They frequently last one, two or three days, and then cease. The patient is apparently healthy in every other way; her functions are normal, and she has never had catarrh, while her ears and nose seem to be healthy and normal. After a thorough examination I made the diagnosis of *tinnitus aurium* from hyperæmia of the brain, and gave the patient ergotin in large doses. This produced no relief. Then I advised bleeding; but the patient did not consent until just before leaving here, and as she had to ride home one hundred miles by wagon I refused to perform venesection then, but prescribed bromide of potash in large doses. This seemed to promise permanent relief; but, after six months of such treatment the patient writes as follows; "At first I seemed much better, but the medicine seemed to lose its effect, until finally, within the last three or four weeks, I am as bad off as ever. I am so disheartened and so annoyed with this interminable noise in my head, that it is with difficulty I can settle myself at anything. My head becomes tired and heavy with a dull fulness, until I am almost bewildered. I sleep better than last summer, my bowels have been very regular, my appetite good—too good, for at times I am troubled with dyspepsia. I still cling to the hope that I may find relief; yet I get, oh! so weary of mind and body, with no rest day or night, only when asleep. I get nervous at times and am almost afraid to sleep, fearing I scarce

dare say what—that the poor weary and worn machinery might give out—not in death, but worse." She further adds: "I am well in every other respect but this one." After this I advised the patient to come and be bled, and I prescribed for her bromide of potash in large doses, with tincture of aconite, and a strong purge every few days.

Arizona, W. N. S.
February 15, 1888.

Onanism and Masturbation.

EDITOR MED. AND SURG. REPORTER:

Sir:—There is one subject upon which I would like a little information, and that is, if custom has made the terms "masturbation" and "onanism" interchangeable? They seem to be so regarded, almost all the writers in the medical papers that I see, so use them. The medical dictionary says "masturbation is self-pollution with the hand," and "onanism is masturbation."

I was taught, and still believe, that masturbation is a solitary vice, that may be performed by one individual of either sex, while onanism requires the co-operation of two persons of opposite sexes. Whatever may be the meaning of masturbation, a clear idea of onanism may be found in the book of Genesis, chapter xxxviii, and verse 9, where the name of one of the parties will be found to be the same as that given to the like act of the present day. A. BURT, JR., M.D.

Wakefield, Kansas.
Feb. 28, 1888.

[Our correspondent is right. The term "onanism" is used incorrectly when applied to masturbation. *Onanism* consists in withdrawing the male organ from the vagina before ejaculation takes place. *Masturbation* is provoking the sexual orgasm by unnatural and mechanical means. Originally the word was applied only to such provocation in which the hand was employed. But at present it is used to indicate any unnatural and mechanical process by which the orgasm is excited.—ED. REPORTER.]

—Mr. G. J. Romanes has been elected Fullerian Professor of Physiology at the Royal Insttution, London. He intends to devote the three years of his professorship to one continuous course of lectures on "Before and After Darwin." This year's course—"Before Darwin"—will give an historical survey of the progress of scientific thought and discovery in biology from the earliest times till the publication of "The Origin of Species." Next year's course will be on "The Evidences of Organic Evolution," and the third year's course on "The Factors of Organic Evolution."

NOTES AND COMMENTS.

A Possible Carrier of Contagion.

Dr. D. Lichty, of Rockford, Ill., writes to the *Medical Record*, March 3, 1888, that in an active and extended experience of twelve years in country practice, he has observed that it is the custom among the farmers, especially the younger families or beginners, to make butter in the house in larger or smaller quantities; and in winter-time, to prevent the milk from freezing, it is usually kept in the kitchen, which is also the living-room, and often the only place in the house where a constant fire is kept. In this room the convalescents stay, and to it are often carried the sick, whatever may be the nature of their illness, whether diphtheria, scarlet fever, or what not, because it is probably the only room where an attempt at equable temperature would be successful. Here the milk from which butter is made is kept in large, shallow pans, sometimes on open, temporary shelving, but more frequently in "safes"—a a light wood cupboard with wire gauze or perforated tin panels at the ends, and folding-doors of the same material. Now there is nothing in this, he says, to prevent the exhalations, desquamations, or disease-germs from being absorbed—and nothing possesses absorbent properties more than fresh milk. Or it may only fall on the surface of the milk, from which it, with the cream, is carefully skimmed until sufficient is gathered for churning, when it is made into butter, packed and carried to its home market, from thence to anywhere and everywhere, without ever having been subjected to any influences, either thermal or chemical, to destroy or impair organic life.

Dr. Lichty also seen the mother, who was the housekeeper and only nurse, leave a large wooden bowl full of butter, in which her hands and arms had been immersed nearly to the elbows, and follow him through two adjoining rooms, in which her children were sick with scarlet fever, to give him the history of their illness the night previous, receive directions and instructions, and then return to her butter-packing without stopping to wash her hands. And this butter was sought by local dealers, shipped to city markets, where well-watched and carefully isolated innocents developed those mysterious *de novo* cases of scarlet fever.

Treatment of Nose-Bleed.

In the *North Carolina Medical Journal*, February, 1888, Dr. N. B. Herring gives

some practical hints under the title "Little Things in Medicine." The following is his treatment of epistaxis:

Take a piece of tough, raw, fat, salt pork, cut it wedged shaped, four inches long, half inch thick, and three-quarters of an inch wide. Force it into the bleeding cavity—*clear through into the pharynx*—and the work is done. It is antiseptic, painless, and never fails to stop the hemorrhage. It is easily removed, and the lookers-on are often solicitous to know what you put on the meat to produce such marvellous results. A hint to the wise is sufficient.

Mütter Lectures.

Dr. O. H. Allis will deliver a course of lectures on the Surgical Pathology of the Articulations, on Tuesday and Friday evenings, at eight o'clock, at the College of Physicians, Philadelphia, beginning March 6, and ending April 6.

The Fellows of the College and the medical profession are invited to attend these lectures, which are delivered under the provisions of the will of the late Dr. Mütter, and under the auspices of the College of Physicians of Philadelphia.

The German Crown Prince's Condition.

The following official bulletin from the physicians attending the Crown Prince gives the most exact information about his condition which has been furnished for a long time:

San Remo, March 6, 11 A. M.—In view of the reports published in the press, alleging differences of opinion among the physicians attending the Crown Prince of Germany, the undersigned declare that, as regards their ideas of the nature of the illness, no such divergencies exist. Just as little do they maintain that a dangerous turn in the malady is imminent. The sole responsibility for the conduct and treatment of the case remains, as prior to the recent operation, in the hands of Dr. Mackenzie. In the interest of the august patient, as well as of the peoples who esteem, love and revere him, the doctors once more ask German and foreign papers to abstain from all discussion concerning his illness or the methods or instruments used in his treatment.

The local disturbances in the larynx have not appreciably altered. The wound has healed and the canula lies comfortably. The patient's lungs are in a healthy condition. The cough and expectoration have diminished. The patient's strength is more satisfactory. His appetite is increasing. There is no digestive disorder, no pain on swallowing, and no headache. He sleeps, with interruptions, for hours together.

As Dr. Bergmann's mission has terminated, he will leave shortly. (Signed)

Mackenzie,	Hovell,
Schrader,	Bergmann,
Kraüse,	Bramann.

Leprosy in England.

The *Brit. Med. Journal*, in its summary of leprosy for the year 1887, says: In the *Journal* of June 11 (p. 1269), Professor Gairdner communicated a very interesting case of the occurrence of leprosy in a boy, the child of British parents, apparently as the result of vaccination from a tainted source. More lately, a discussion has been carried on as to the contagiousness of leprosy, and its communicability by contact and inoculation, as well as by vaccination. Letters have been received from the medical officers of leper asylums in the East which have reopened the whole question; whilst in a letter to the *Times* of November 8, Archdeacon Wright sought to show that leprosy is increasing in this country, and that stringent measures are called for to keep all lepers apart from the healthy. A committee of the Royal College of Physicians has presented a report on this subject (July 15), in which they hold that leprosy is not contagious in the conventional sense of the term, or only so in low degree and under exceptional circumstances, and that compulsory measures of segregation of the affected are not justifiable. In the *Journal* of Nov. 19 (p. 1120), cases are cited from Dr. Monro's work on the *Etiology and History of Leprosy*, which show the nature of the evidence in support of the theory of contagion.

Treatment of Malignant Tumors of the Breast.

In the *Glasgow Med. Journal* January, 1888, Mr. John Fagan, surgeon to the Royal Hospital and Belfast Childrens' Hospital, publishes a paper upon the treatment of tumors of the breast. The following is a summary of his views regarding the treatment of malignant tumors:

"1. That in many of the very worst forms of advanced painful, ulcerating scirrhus, where there is no immediate danger of death from marasmus or visceral complications, the breast may be removed with great benefit and relief to the patient.

2. That all cases of malignant growths of the breast, as soon as they are diagnosticated,

should be removed at once by operation and in the thorough manner I have described.

3. That all doubtful cases should be dealt with in the same way.

4. That all recurrent growths should be removed at their earliest manifestation.

5. That all non-malignant neoplasms, as soon as they show a tendency to enlarge, and especially between the ages of twenty-five and forty years, should be removed without delay."

The following quotation from the writings of Jonathan Hutchinson bears forcibly on this point:—'Too late! too late! is the sentence written, but too legibly on three-fourths of the cases of external cancer concerning which the operating surgeon is consulted. It is a most lamentable pity that it should be so; and the bitterest reflection of all is, that usually a considerable part of the precious time which has been wasted has been passed under professional observation and illusory treatment.'

When the doctrine of the precancerous stage shall he widely adopted, and when surgeons generally shall recognize the propriety—let me say the duty—of opertion for purposes of prevention, then, and I believe not till then, shall we witness a considerable reduction in the mortality of cancer."

Tubercular Laryngitis.

Dr. Henry L. Swain, lecturer on diseases of the throat and ear in Yale College, concludes a long paper on tubercular laryngitis in the *N. Y. Med. Journal*, December 17, 1887, with the following summary of what he has said, which he quotes from Prof. Massie, of Naples:

"1. We are still in want of some remedy or remedies to effect a cure of laryngeal phthisis.

2. Notwithstanding this want, the local treatment of the disease is incumbent on every physician.

3. Many cases quoted by various writers are of extremely hypothetical nature, inasmuch as they have not been a sufficient time under observation.

4. Cocaine, iodoform, iodol, and sublimate are perhaps the best of the local remedies (to which I would add lactic acid, differing from the writer, who doubts its great efficacy)."

A Druggist's Prerogative.

The *National Druggist*, January 15, 1888, says: While on the subject of the responsibilities of druggists under the liquor laws, the decision of Judge Guthrie, of Topeka, Kan., in the case of Trehy *vs.* Holliday, is an important one, as clearly defining the duty of the druggist under certain embarrassing circumstances. Trehy obtained a prescription for gin from a physician who was unknown to the pharmacist, and the latter, knowing the patient to be a habitual drinking man, refused to fill it. Trehy forthwith sued for heavy damages, alleging that his health had been damaged by the failure to get the prescribed "medicine." When the case came up for trial, Judge Guthrie decided that the complainant had no cause for action, and that Holliday, when he refused to give him the liquor, was not simply exercising the discretion left him under the law, but obeyinig the spirit, if not the letter, of the statutes.

Increase of Lunacy in Austria.

On the occasion of the opening of the Session of the Lower Austrian Landtag, the Landmarschall (Count Kinsky) confirmed the great increase of lunacy, remarking that all the country asylums were filled to overflowing, and that a further erection of similar institutions in Kierling-Gugging was necessary. This increase which had been repeatedly confirmed from various quarters, during the last decennium, found its explanation in the difficult struggle for existence, in the exciting haste to become rich, and the unsatisfied struggling and striving after place and power, and in the never-ceasing trouble and anxious care produced by the daily blighting of one hope after another. The so-called embitterment of character gradually degenerated into a mental disturbance; the slightest neurotic disposition led to a disturbance of the mental equilibrium. In men, additional factors were alcoholic abuses; in women, anæmia, and exhaustion of all kinds; in both sexes, strong passions, mental and bodily strain, and a faulty development of the power of mental resistence, which easily led in consequence of hereditary taint to the temporary or even permanent destruction of cerebral equilibrium. An improvement in the sad condition was not to be speedily hoped for, the disease is intimately associated with the solution of great social problems, which only to a slight extent lie within the province of the physician.—*Medical Press and Circular*, December 24, 1887.

Antipyrin in Hemoptysis.

Dr. Olikhoff writes to the *Russkaya Meditzina* that, having seen in some medical journal that antipyrin possesses hemostatic properties, he made use of a solution of

ninety grains in six ounces of water for inhalation in six cases of hemoptysis. He ordered five or six inspirations to be taken through the inhaler every half hour or hour. This had the effect of diminishing the hemoptysis at once, and of rapidly arresting it. And in the same journal, No. 36, 1887, Dr. Olikhoff states that he employed antipyrin with brilliant results in six desperate cases of hemoptysis, after various ordinary hemostatic means had utterly failed. The drug was administered in the shape of a solution of 1½ drachms to 6 ounces of water, which was inhaled every half hour or hour, five or six times a day. The hemorrhage was strikingly diminished in the course of the same day, ceasing altogether on the next one. In all the cases a marked decrease of the (febrile) temperature was also simultaneously observed. All Dr. Olikhoff's patients were suffering from broncho-pneumonia.—*Quarterly Therapeutic Review*, January, 1888.

The Gonococcus in Court.

Some little time ago in Belgium a man was accused of the rape of a little girl. On the clothing of the accused, and also on that of the alleged victim, spots of pus were found and handed over for examination to a physician and a pharmaceutist of the first class. These experts declared the pus to be gonorrhœal; whereupon the defending counsel demanded proof of the presence of gonococci. Dr. Castiaux, Professor of Forensic Medicine at Lille, was therefore called upon to make a fresh examination of the spots, with the object of determining the existence or non-existence of micro-organisms. Dr. Lober, who took part in the examination made pure cultivations of the pus on various media, and finally on sweetened and peptonised agar, and by this means was enabled to confirm the gonorrhœal nature of the pus. —*Medical Press and Circular*, Dec. 28, 1887.

Report on the Health of School Children.

Dr. Moreau Morris, Sanitary Inspector of the New York City Board of Health, makes the suggestion that principals of public schools be required to make a special report every month, for the Board of Health, of the percentages of absence on account of illness, in the several grades of pupils, so that investigation and remedial action, if necessary and practicable, may be had in cases which appear extraordinary, or which may arise from insanitary conditions or mismanagement in the schools, imperfect isolation of contagion, etc. This, as the *Sanitary Era* says, ought to be done everywhere.

NEWS.

—Dr. Edward Jackson has been elected Professor of Diseases of the Eye, in the Philadelphia Polyclinic.

—Dr. John H. Musser has been elected attending physician to the Presbyterian Hospital in Philadelphia.

—An epidemic of measles is raging in Washington City and the Government departments are said to be short of clerks.

—The Medical Department of the Arkansas Industrial University held its commencement March 1, 1888, and graduated 20 men as physicians.

—The death of Prof. Ernst L. Wagner, Director of the Medical Clinic at Leipsic, is announced. He was editor of the *Archiv für Heilkunde*.

—The U. S. Government has decided that certain bulbous-rooted plants, known as "Convallaria," or "Lily of the Valley," are entitled to free entry.

—The Court of Claims has allowed the claim of Dr. John S. Billings $1,500 for mileage, while travelling in Europe under orders from the Secretary of War.

—The Philadelphia Dental College graduated 119 men, Feb. 24, 1888. The Dean, Dr. J. E. Garretson, said that it was the largest class that had ever graduated from any dental college in the world.

—Dr. Henry F. Lyster, of Detroit, has been appointed successor to the late Dr. A. B. Palmer as Professor of the Principles and Practice of Medicine in the Medical Department of the University of Michigan.

—On March 1, fire broke out in the northwest pavilion of the Cincinnati Hospital, driving patients out of their wards, but injuring no one. The fire was caused by the leakage of gas, and broke out in the upper part of the building.

—President Boyles, of the New York Board of Health, said March 1, that there had not been a single case of small-pox in the city since February 25, and only one case on that date. He considered the disease practically stamped out for this season, and attributed this desirable state of affairs to the rigid vaccination of all the tramps and nomadic tenants of low lodging-houses that the Department can lay its hands on. There has also been a marked decrease in diphtheria of late. Scarlatina has somewhat increased, but not to any alarming extent.

HUMOR.

SCENE, a connubial bed. Time, 2 A.M.—Wife, "Charlie! Charlie! do stop snoring. Turn over on your side." (Nudges him. Husband, only half awake, grunts, turns on his side, and continues to snore). Wife remembers a line from an article called "How to prevent Snoring." Gives her husband a second nudge, which elicits another grunt. "Oh, Charlie! If you'd keep your mouth shut you'd be all right." Charlie (still semi-conscious)—"So would you!"

TO BE TAKEN AT BED-TIME.—The following is sent us by Mr. J. C. Spring, of the Bear City Drug Store, Bear City, Ark., who states that it is a *bona fide* prescription, sent in by a registered physician of that region. If any of our readers are tired of life and want to leave this world "a screechin' an' a screamin' for joy," as an old negro preacher once told us concerning his wife, who had "jis' died of de rebilious colic," he might try this at bed-time:

"Podoflin 5 cts. Leptandra 5 cents, ruberb 5 ct. Pownded balsam-phur 5 cts Turpantime 5 cts Niter oz 10. To be mixed and took at bed time."

Mr. Spring volunteers the remark that when any of our readers beat this record for a registered physician anywhere, he will go him one better, which he holds in reserve. —*National Druggist*, February 1, 1888.

BILL NYE AS A SCIENTIST.—He elucidates a knotty point in anatomy for a Louisiana man.—*Mr. William Nye, New York City.—Dear Sir:* Knowing the vast extent of your attainments in the domain of natural science, and being myself an earnest seeker after truth in the same field, I feel free to ask you to explain the meaning of the following sentence, which you will find at page 35, in chapter iii, of a book on "Comparative Anatomy and Physiology," by F. Jeffrey Bell, M.A., Professor of King's College:

"It happens to many gastrulæ that, their blastopore closing up, they develop an investment of cilia on their epiblast and swim about for a time freely in the water."

If you can shed any light upon the meaning of this sentence, you will confer a favor upon, Yours respectfully, JAMES KERSON.

Marksville, La., Nov. 7, 1887.

I understand the above perfectly well, but I do not know that I can make it clear to you through the medium of the press. I would much rather see you personally and explain it to you. If I could take you into my laboratory for an hour or two, I could give you a better idea than I can in a limited space here. Could you not come on to New York and have this matter settled?

Gastrulæ, as you know, are of two classes, viz: malignant and intermittent. It is the first class that is most likely to get their blastopore plugged up. Then trouble begins. Cilia begins to erupt on the epiblast, and microbes break out all over the duplex. You can't be too careful about this. A blastopore, if I've got the right idea of what a blastopore is, should be brought in every night, or the boys may get hold of it and plug it before it is ripe. I would rather see an epiblast of mine, or a blastopore, or a gastrulæ for that matter, in its grave, than mixed up with an investment of cilia or any other doubtful financial matter. BILL NYE. —*New York World.*

OBITUARY.

THOMAS B. LESTER, M.D.

Dr. Thomas B. Lester died at his home in Kansas City, Mo., February 24, 1888. He was graduated from the Missouri Medical College in 1850, and was at one time a Vice-President of the American Medical Association.

Official list of changes in the Stations and Duties of Officers serving in the Medical Department, U. S. Army, from March 4, 1888, to March 10, 1888:

First Lieutenant W. W. Fisher, Assistant Surgeon, sick leave extended one month on surgeon's certificate of disability. S. O. 50, A. G. O., March 2, 1888.

First Lieutenant Paul Shillock, Assistant Surgeon (recently appointed), ordered for duty at Fort Assinniboine, Mont. S. O. 50, A. G. O., March 2, 1888.

Changes in the Medical Corps of the Navy, for the week ending March 10, 1888:

Assistant Surgeon E. P. Stone, detached from the Coast Survey Steamer "Bache" and to Hospital, New York, for treatment.

Assistant Surgeon James F. Keeney, commissioned March 1, 1888.

Surgeon, George R. Brush, ordered to the "Omaha" when "Pensacola" arrives at Aspinwall.

Passed Assistant Surgeon Victor C. B. Means, to the "Omaha" when "Pensacola" arrives at Aspinwall.

Official list of changes of Stations and Duties of Medical Officers of the U. S. Marine Hospital Service, for the week ended March 10, 1888:

Hutton, W. H. H., Surgeon. To proceed to Brunswick, Georgia, on special duty, March 5, 1888.

Detailed as president of Board to select site for Gulf Quarantine Station, March 10, 1888.

Carter, H. R., Passed Assistant Surgeon. Detailed as recorder of Board to select site for Gulf Quarantine Station, March 10, 1888.

Wasdin, Eugene, Passed Assistant Surgeon. Granted leave of absence for thirty-days, March 8, 1888.

Bratton, W. D., Assistant Surgeon. Ordered to examination for promotion, March 7, 1888.

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Clinical Lecture.

OPHTHALMIC CLINIC OF THE JEFFERSON MEDICAL COLLEGE HOSPITAL.

SERVICE OF DR. WILLIAM THOMSON.

[Reported by George F. Souwers, M.D.]

We are about to enter upon the consideration of an operation, which, while it has formed the topic of thought and the subject of lectures and writings of most of the leading ophthalmologists of the world is yet, in certain of its phases, an unsettled matter. Periodically, especially for the past forty years, operators attempt to strike out in new directions in regard to it, and just at this time the procedure seems to be passing through a transitional stage once more. If we take up the books of half a century ago, we find that a method of operation was pursued that has almost been relegated to oblivion. At that day we discover, that, while enucleation or excision of senile cataract was sometimes practiced, yet the adherents of the operation by displacement of the lens were largely in the majority, men of prominence of that day taught and wrote of this method as eminently right. Bretonneau, Velpeau, Malgaigne, Bell, Sichel, Pancoast, Lawrence and Smith, names which to-day seem far distant to us, all advocated and practiced it, and claimed to obtain for that time, very excellent results. We find that one of this distinguished number gave directions for the performance of the operation about as follows: The patient lying down or being seated the surgeon stood either in front or behind him, so that he could always use his right hand; the needle was introduced through the sclerotica, about two lines behind the cornea, and was then directed so as to pierce the posterior and inferior part of the lens; the capsule divided, and then the needle being passed above the lens with its concavity looking downward, a simple movement of depression sufficed to cause the descent of the lens into the vitreous humor; laceration of the cells of the hyaloid before depressing the lens being also advocated. Extraction, pure and simple, was especially advocated for cases of well ascertained hard cataract, particularly when occurring in very prominent eyes, and if under the care of men possessing marked digital dexterity. In that day one of the principal duties of the assistant consisted in properly raising and retaining the upper lid in situ, commonly with his fingers or occasionally with a crude form of speculum, great care being taken to make no pressure upon the eye-ball; in fact one of Velpeau's aids is chargeable with having, by undue pressure, entirely evacuated the contents of an eye-ball. The method of extraction fifty years ago was, in most respects, the counterpart of that of to-day. The corneal incision was, however, of greater extent and made in one of three different directions; the favorite method was one by which the knife made section of the upper half of the cornea; in favor of the procedure was the fact that the aqueous humor did not escape as readily as by either of the other two styles of operation, in one of which the knife made an exterior lateral flap of the cornea, whilst in the third form the cornea was separated from the sclerotic at its lower border, this latter section being the least favored on the score that prolapse of the iris into the wound was much more liable to occur. In considering the operation of to-day we have unfortunately to recognize the fact that there is a constant desire on the part of many operators to needlessly modify the method of removal of the cataractous lens. I must place myself decidedly in the category of those who oppose

what would seem to be the coming or rather resurrecting doctrine, namely, the non-performance of an iridectomy as an essential element in the conduct of the case. Liebricht has attempted a modification of the proceeding which I do not feel is at all warranted; in his method of operating a very large corneal wound is made. We all recognize the circumstance that the cornea is a tissue of comparatively low vitality, or that at least its nourishment is not such as to warrant any extensive interference with its supply; this being an admitted fact by all, it does not seem reasonable to make an extensive flap operation for the purpose of allowing the ready escape of the lens. One of the most serious objections to such a section of the cornea, aside from that already advanced, is the increased tendency which such a large wound has to gap. This large flap plan, it is claimed, allows the escape of the lens without the necessity of an iridectomy, thus preserving the natural shape, symmetry and mobility of the iris, and it is the requirement or non-requirement of this latter operation which is the latest cause of contention among ophthalmic surgeons. My experience in this hospital, where I have performed on an average from twenty-five to thirty cataract extractions a year, in all of which iridectomy was performed, has led me to the conclusion that the best results obtainable are secured by this method. In institutions especially devoted to the treatment of the eye, where trained assistants are constantly at hand to carefully look after the cases, it may be that cases of non-iridectomy do well, or fairly well; but I am satisfied that in those cases which receive but the care of the ordinary general hospital, or the even less trained care of private practice, iridectomy should be one of the integral portions of the operation. In the years from 1881 up to the present day, under full antiseptic precautions, but two of our cases have failed to make a good and thoroughly satisfactory recovery; one of these cases, however, may clearly be placed in the category of accidents after operation, extensive hemorrhages in the eye having been induced by the patient striking his head against an iron pillar, while attempting to walk around the ward before the bandages had been removed from his eyes. The operation of von Graefe was evolved by that celebrated oculist in order to avoid hernia of the iris, and also to give greater light passage in case of complications due to iritic adhesions and pupillary occlusions subsequent to the immediate operation. My experience has taught me that even with a large coloboma a certain number of bands of organized lymph may be formed and interfere to a greater or less extent with the acuity of vision, as well as the appearance of the eye. If this be so with an iridectomy having been performed and thus all the chances of success on the operator's side, how much more liable to an unfortunate issue must be an eye left, in a greater or less degree, to the tender mercies of an iritis? Granting that, as happens at times, adhesive bands are thrown across the pupillary area after operation with iridectomy, it is but a simple matter to introduce a fine needle knife, and turning its cutting edge against the prominent edge of the bands cut them through and allow them to roll out of the line of vision or be absorbed. Very recently I have done this operation on one of our hospital cases where bands interlaced in many different directions, with the happiest results. Where innovations in eye-surgery are manifestly beneficial, I am in hearty accord with the progress of the profession; but I must admit myself conservative where, as in this procedure, I do not feel satisfied of the utility of the method. Personally, I prefer the von Graefe operation, or a slight modification of it. My knife, having a very narrow blade, being entered a little to the outside of the sclero-corneal junction, is directed slightly downward till I have made my puncture, this being at about the upper fourth of the cornea; then the instrument is carried directly across to a corresponding point on the opposite side, for its exit. The knife is now carried upward till about one millimeter from the superior juncture of the sclera and cornea, when the cut is changed in direction to one upward and slightly outward, the knife thus making its exit just at the point of union of the sclerotic and cornea. In most cases a portion of the iris at once falls into the wound, where it is caught by an iridectomy forceps and a portion excised. A crucial incision of the capsule of the lens is then made and the lens at once, by slight pressure from below upwards and a little backwards, makes its exit. All lens detritus viewable is delicately manipulated and removed, after which the following wash is instilled in the eye:

℞ Hydrarg. biniod. ..... gr. j
Potass. iod. ..... gr. x
Aq. rosæ ..... ℥j

Ten drops of this solution is added to one ounce of water and the eye washed carefully.

This makes, for ophthalmic purposes, one of the most satisfactory of germicides. A few drops of a four grain solution of atropia having been placed in the eye, a light absorbent cotton-dressing is made and held in place

by a bandage extending over both eyes, and terminating in strings or ribbons tied at the back of the head. I may add, that I generally employ a bandage which is knitted out of a fine brown yarn, the width being about three inches, the length, exclusive of the ribbons for tying, about six or seven inches. Frequently, instead of the cotton-dressing, I use strips of surgeon's silk adhesive plaster over the closed lid, the bandage being placed over these. A few drops of atropia are instilled every day, by simply lifting the corner of the bandage and introducing the point of a pipette beneath the lid; as a rule the eye is not examined particularly for three or four days, when it is generally found in very excellent condition. About one month subsequent to the operation glasses are fitted for the near and far point; the cases remain in hospital about ten days, though advised to report occasionally for inspection every few weeks for two or three months.

In the case before us we have an example of what a penetrating blow of the cornea may produce; the young man's eye is in a much more favorable condition than it was a few weeks ago when he first applied to this clinic for relief. Having been struck on the eye, the patient did practically nothing for himself for four or five days; then, becoming alarmed, he applied here. The eye was injected, angry looking and painful; the cornea was hazy and tending to abscess and slough; altogether the case looked very unfavorable. The condition present was almost identical with what we would find in a cellulitis due to erysipelas. The treatment consisted in tapping the minute suppurating points and in keeping the eye thoroughly under the influence of a solution of two grains of eserine to an ounce of water. For what little haziness remains, we shall employ dustings of the cornea with levigated calomel. The sub-carbonate of bismuth has been also suggested for the removal of these leucomatous conditions; but our experience here has been that in some, and nearly all eyes, there is more or less a sense of irritation and grittiness experienced by the patient when bismuth is used, whereas no complaint is made when the mercury salt is employed.

—Dr. William H. Welch will deliver the Cartwright Lectures for 1888, before the Alumni Association of the College of Physicians and Surgeons, New York, April 5 and 12, at 8.30 P.M. His subject will be "General Pathology of Fever."

Communications.

SEX AND CONSUMPTION.

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"Our method of discovering the sciences," says Bacon, in the *Novum Organum*, "is such as to leave little to the acuteness and strength of wit." It is to be feared that Bacon's method is not always followed by medical men; it must be obvious to the more critical that in their productions there is very often strong evidence of too much "acuteness and strength of wit." Now, in scarcely any branch of medicine are these qualities more frequently apparent than in that of statistical medical studies; and in no other is the perversion of the inductive method of study more objectionable. Medical statistics may be in themselves more or less defective, but such as they are, they should be studied according to the method of science and for the sole purpose of the discovery of truth.

These remarks, and those following, have been in part suggested by certain statements appearing and reappearing in the journals of the day in regard to the relation of sex to the occurrence of consumption of the lungs. It seems to me that the vast collections of mortality statistics at our disposal should throw a fair amount of light on this subject. It is not a very complex matter. The question is: Do more males than females become affected with consumption? It being a disease which sooner or later proves fatal, the number of deaths would seem at first view to indicate the number of cases. This, however, is not so; for many persons affected with consumption are cut off by intercurrent diseases. Just how large the proportion of those dying in this way may be there is no means for determining, but it is, doubtless, very considerable. And it is safe to say that the proportion is far greater in the young than in the comparatively old; for the reasons that the young are greatly in the majority, and the tendency to such disease is stronger in early than in later life. It would be idle to argue that sex *per se* is accountable for the greater or lesser mortality of men or women from consumption. No doubt sex has something to do with it; for the two sexes differ in strength and otherwise. The mode of life is probably of more significance than the sex. The two are not similarly exposed to influences of the various kinds affecting health. The life of the young woman is apt to be less hygienic than that of

the young man. Among persons no longer young a reverse statement is probably true. Mature men do not as a rule live as healthfully as mature women. Apart from necessary exposure in the struggle for existence, a large proportion of men ruin themselves by dissipation of one kind or another, break themselves down and bring on diseases, consumption being a common one.

The mortality statistics available for the determination of the question of the greater prevalence of consumption in one or the other sex, are generally only those of large communities. The number of applicants for treatment at a dispensary, or the number of inmates of a hospital for chest diseases, or the number of cases a particular physician may have treated, is a poor basis for even an estimate. Women, and especially the young women, are more likely to be treated exclusively at home than men. Then, even the general mortality statistics, if taken in the aggregate, are not likely to indicate very much on the subject in question. The whole number of deaths of men and of women from consumption of the lungs may be equal, and yet it would not follow that the two sexes are equally prone to the disease. This is obvious from preceding statements. It is well to bear in mind that in some communities the number of persons of either sex is not the same. In some of our Eastern States women are considerably in the majority; and hence, other things being equal, one would expect more deaths of women than of men. With correct statistics it is well to study the proportion or ratio of the deaths according to sex, to the population of either sex. The census statistics of the United States being very incomplete, do not enable one to gain a knowledge of the proportion of deaths to the population.

The age of the victims of consumption should be considered; and herein mortality statistics are often defective. In this respect the statistics of our great cities are very defective. One can gather from the statistics of Philadelphia that so many minors and so many adults have died from consumption, but that is all.

The census statistics are the ones of chief value to us in determining the question at issue. And these are somewhat misleading, because there is a greater proportion of deaths unreported of women, and especially of young women, than of men. A few years ago I became interested in the question of the relative frequency of consumption in the sexes at the various periods of life, and contributed an article on the subject to the MEDICAL AND SURGICAL REPORTER, for January 1, 1881. That article was based mainly on the statistics furnished by the United States census of 1870. The outcome of the study was very striking indeed, and should command the attention of every student of this terrible disease. Since the article referred to was published the mortality statistics of the United States census of 1880 have come to hand, and in connection with those of 1870, afford excellent data for comparative study.

The following table gives the mortality of males and of females from consumption of the lungs, at different ages, in the United States, during the census years ending with June, 1870 and 1880:

	1880.		1870.	
Age.	Males.	Females.	Males.	Females.
Under 5	2460	2248	2274	2209
5–10	447	640	459	494
10–15	583	1324	501	1056
15–20	2409	5412	1756	3431
20–25	5312	8491	3938	5138
25–30	4788	7188	3904	4684
30–35	3912	5421	3329	3556
35–40	3769	4560	3262	3215
40–45	3075	3431	2631	2422
45–50	2771	2623	2423	1843
50–55	2481	2119	2130	1655
55–60	2063	1531	1657	1221
60–65	1979	1631	1704	1407
65–70	1629	1399	1341	1172
70–75	1272	1128	1118	993
75–80	839	811	745	696
Over 80	536	608	726	706

The essential features of my remarks on the statistics for 1870 are as follows:

"In persons under five years of age the mortality from consumption of the lungs among males is greater than among females.

"From five to ten years of age females are more liable to have the disease than males.

"Among persons of from ten to fifteen, over twice as many females as males succumb to the disease.

"Among persons of from fifteen to twenty nearly twice as many females as males are destroyed by the disease.

"Consumption of the lungs among persons of from ten to twenty years of age destroys about two females to one male.

"Among persons of from twenty to twenty-five, about a quarter more females than males die of the disease.

"Among persons of from twenty-five to thirty, about a sixth more females than males die from the disease.

"Among persons from thirty to thirty-five, about a twelfth more females than males die from the disease.

"From the age of thirty-five forward there are more deaths of males than females from the disease.

"From forty-five to fifty, from fifty to fifty-five, and from fifty-five to sixty, a third more males than females die from it."

The whole number of deaths of males in the census year was 33,971, and of females 35,925. From these and other figures "it would appear that as a whole there is a considerably larger number of deaths of women than of men from the disease." The figures for 1880 show more conclusively than those for 1870 that more deaths of male than of female children are attributable to consumption of the lungs. As stated already, there are more deaths of women than of men unrecorded. As there are more male than female children, one would expect the aggregate deaths from the disease to be somewhat more. The figures for 1880 indicate a much heavier mortality of females than of males of from five to ten years of age from this disease. The ratio is about three to two. The figures for 1870 show that over twice as many females as of males, ten to fifteen years of age, die from the disease. Those for 1880 show a still greater fatality among females of such age. In 1870 the deaths of females of from fifteen to twenty years of age were not twice as numerous as those of males of the same age. In 1880 they were over twice as numerous. The figures of 1870 show the deaths of persons from the disease, of from ten to twenty years of age, to consist of about two females to one male of the victims. In 1880 there were considerably more than two females to one male. In 1870 there were about a quarter more deaths of women than of men of from twenty to twenty-five years of age, while in 1880 there were over a third more. Of the deaths of persons twenty-five to thirty years of age, there were, in 1870, about a sixth more women than of men, while in 1880 there were about three women to two men.

In 1880 there were about a third more deaths of woman than of men of from thirty to thirty-five years of age, whereas in 1870 there was only about a twelfth more. In 1870 the deaths of men exceeded those of woman among persons over thirty-five years of age. In 1880 the deaths of women are considerably in the majority, until after the age of forty-five years. Among persons over forty-five years of age nearly a quarter more men than women die from consumption of the lungs. Of the deaths attributed to consumption in 1880 there were 40,512 of males and 50,758 of females, or about four of the former to five of the latter. The difference was not so marked in 1870. As the living males in 1880 were 25,518,820 and females 24,636,963, it follows that there were 630 males alive to one death of the same, and 406 females. But it should be remembered that really the relative mortality is much heavier, because the record of deaths is very defective.

The statistics of both 1870 and 1880 show that far more females than males die from consumption of the lungs. In the earlier years of life the mortality of females is shockingly greater than that of males. And were it possible to estimate the number of those who would die early from consumption, if not cut off by intercurrent diseases, the greater prevalence of consumption among females than males would be still more evident. Evidently a theory of the cause of consumption based on the assumption that males are more subject to the disease than females is incorrect. It can have little or nothing to support it save what may spring from "acuteness and strength of wit." The more markedly pectoral character of breathing in women compared with men, might be put down as a cause rather than a preventive of consumption; for it is in the years that females in general favor that character of breathing by tight lacing that consumption is most destructive to them.

Apart from what heredity and the difference in their mode of life may have to do with the matter, it is more than probable that the more delicate constitution of females than of males renders them the more liable to become affected with consumption of the lungs. As is now generally believed, it is largely a disease whose origin is dependent on the state of nutrition of the body. Hence, all the multitudinous causes which tend to produce degeneracy tend to produce consumption, and *vice versâ*. To attempt to trace the disease to the mode of breathing or any other single cause, whether predisposing or exciting, is not very reasonable. Any theory of the kind must rest in the main on "acuteness and strength of wit."

—The *St. James Gazette* states that a Russian officer was recently taken to a hospital in St. Petersburg, suffering with a gun-shot wound in the region of the heart. The officer confessed that he had shot himself in order to avoid shooting the Czar, which he had been ordered to do by a secret society to which he belonged.

THE SEWING-MACHINE AND ITS EVILS.

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In the MEDICAL AND SURGICAL REPORTER, December 10, an editorial mentions the dangers arising from the use of the sewing-machine, especially with reference to diseases of the uterus. For many years I have been giving attention to the operating of the sewing-machine, and have become quite skilled in its use. But since reading your article I have been giving the matter especial attention, with a view of ascertaining wherein these evils lie. I have been long convinced that much misery would be abated if means could be discovered whereby these machines could be run without injury; for that injury does result must be apparent to the most cursory observer. As many of your gynecological readers will doubtless think the following pages overdrawn, incorrect or unimportant, I will to such hazard the remark, that the outrages perpetrated upon women under the cloak of science, make it incumbent upon physicians to "cudgel their brains" to discover, if possible, some means of preventing incurable diseases; and if any one doubts my assertions, let him take up the "wage of battle" and prove them false. I assert that very many uterine ailments, especially in the unmarried, are caused by the constant use of the sewing-machine; and those not primarily so caused, are secondarily very much aggravated by its use. Any one can easily experiment with a sewing-machine, for nearly every dwelling has one; and as the general principles of their operation are the same, no difficulty will be found in proving whether my position is well or ill-founded. Suppose a woman of ordinary stature, seated on a common cane or "Windsor" chair, with both feet on the pedals. In this position the knees are almost, or quite, on a level with the superior surface of the thighs. From constriction of the corset, the abdominal parieties below the umbilical region, are pressed upon the surface of the thighs; hence any movement of the knees in a perpendicular direction must either compress or relax the abdominal walls. In addition, the motion necessary to propel the machine, calls into play several muscles, notably the quadriceps extensor and sartorious of the thigh, and the tibialis anticus and gastrocnemii of the leg, not to speak of several in the foot. The pedals of nearly all machines are so arranged that two motions are necessary to "work" them, namely, up and down; thus differing essentially from the old-fashioned spinning-wheel treadles, which went up of itself, and only required to be pressed down. Morever, in spinning only one foot was used, while the sewing-machine requires both feet. The axis on which the treadle works is so placed that the instep is exactly over it, and the feet when at rest are in a horizontal and natural position; but when the machine is in motion the thighs are pressed hard against the abdomen once for every revolution of the fly-wheel. If the machine is running slowly no evil is apparent, but when it runs with great rapidity, as it nearly always does, the contents of the abdomen, such as bladder, uterus and viscera, generally must get quite a jolting. Also, the action of the muscles of the thighs, especially at their insertion in the neighborhood of the pelvis, would necessarily produce exhilaration, if not excitement of the generative organs; because when the knees are together, if elevated (to counteract the pressure of the abdomen, which would tend to separate the thighs), another set of muscles are called into play, which have rather a close relation to the external genitals. These muscles are the adductors. If the operator could sit in an upright position this condition of things might be borne, but to be able to see her delicate work, she must bend her body forward, thereby enhancing very greatly the just mentioned evils. The abdomen is subjected to still greater pressure, and of course the enclosed organs must suffer in proportion.

Machines as a rule are hard running from a variety of causes. Women are usually only anxious that the machine should do good work; and though it may require all her force to run it, exhausting her thereby, yet if the stitching is correct, all other defects are condoned. Machines become gummy easily from dust and shreds of cloth getting mixed with the oil, and as very few women have much mechanical *conceit*, (I say conceit advisedly), machines so hampered are seldom if ever cleaned. Without good oil, well applied, no machinery will run easily. Fear of soiling goods on the one hand, and pure carelessness on the other permit many good machines to run badly. The tension of the belt has much to do with the easy running of sewing-machines. The tighter the belt the more difficult it will be to run the machine. To make the belt loose enough to run easily the machine must be in good condition, or the belt will slip on the pulley. In so far, we do not see that the machine is always to blame for the evils ascribed to it. But if the

sewing woman were a mechanic, cleaned her machine regularly, kept it lubricated with the best sperm oil, saw that the belt-tension was correct, and in fact got everything out of the machine in the best and most workman-like manner, yet if her usual position at the machine is mantained, all this would only modify, not cure the evil. The machine itself then is at fault, partly in construction, partly in position. The watch-maker is compelled to so cover the works of the time-piece that dust and dirt can reach them only by the grossest carelessness. Inventors generally endeavor to put the propelling power on the long arm of the lever. But in the sewing machine, dust, dirt, shreds and oil are allowed free access, and while the feet propel the short arm, the coupling rod and machinery attend to the long arm of the lever. The belt is of so narrow a surface, as to require too much tension to move the machinery at all.

But in the position of the operator lies the greatest defect. A woman of medium stature seated at a machine, has the thigh and leg forming a right angle at the knee, while the leg and foot alternately form an obtuse and acute angle at the malleolus. The operating of the treadles for any length of time will exhaust the posterior muscles of the leg from want of purchase at their superior extremity. These muscles, especially the gastrocnemii, being intended by nature to be operated with the femur and tibia in direct line. On the other hand, the anterior muscles of the leg, from too much tension can with difficulty contract or relax sufficiently to materially assist the former set of muscles. In fact the quadriceps extensor is required to raise the foot. Except the adductors and quadriceps extensor the muscles of the thigh are nearly at rest, and are injurious only from the irritation produced by pressure. The adductors from their attachment to the pubes and ischium would in strong contraction, have a tendency to excite the sexual feeling, while the pressure of the thighs would so disarrange the viscera, that we could easily imagine prolapsus, metritis, cystitis, even erythism and orgasm if you please, ending in complete wrecking of the whole system. With the foregoing array of difficulties attending the use of the sewing-machine, is it any wonder that so many otherwise healthy women should succumb to its baleful, health-destroying influences? Yet the matter can be remedied.

There are three methods by which these dangers could be almost, if not, quite, altogether avoided. First, in improvement in the machine; second, in improvement in the chair; and third, in improvement in the position of the operator. Usually, unless of small stature, a women when seated at the machine on a common chair has the knees on a level with the thighs, and directly under the needle-bar, requiring the operator to stoop forward in order to see the work. To overcome this defect, a machine should be made so that the needle-bar would be near enough to the operator to allow her to sit in an easy and natural position, *i.e.*, within six or eight inches of the body, and the treadles so placed that her lower extremities would be nearly in a straight line at the knees. To accomplish this a radical change would have to be made in all machines, old and new, entailing great expense, which of course, the very persons most needing help could not afford. The belief prevails that sewing-machines are nearly, if not quite perfect, yet while all other parts have from year to year been improved, the method of driving the machine is essentially the same as it was under Howe's first patent. He will be a public benefactor who soon makes an advancement in this regard.

The second method of avoiding the evils incident to sewing-machines will be found more practicable, at least with regard to expense. A common chair, if perfectly flat on its upper surface, and cushioned, is perhaps the best seat commonly found in our households for a woman to occupy while at the machine. A chair hollowed out in the seat or a cane-seated chair, from the undue pressure of the anterior ridge must do harm from cramping the muscles or nerves of the posterior surface of the thighs. Several years ago, in a number of the MED. AND SURG. REPORTER, a writer called attention to the ease with which a sewing-machine could be run, if the operator would sit on a chair or stool slanted upwards and backwards with a rise of about four inches to the foot. Having given this hint a thorough trial and having had the experience of a number of others, I can safely say that the suggestion is a good one. Without going into any extended argument, I will simply add that it possesses all the advantages with none of the disadvantages of the common chair, and I know no better stool for this purpose than Briggs's organ-stool, which by a simple adjustment can be raised or lowered, to suit tall or short persons, yet with the proper inclination. There is, however, one difficulty connected with this method. To get a good purchase on the treadles the seat must be

comparatively high, thus taking the work further away from the eyes of the operator. But good though it be, will women generally adopt this method? No! And why? Because when a woman wishes to sew she picks up the first chair that comes to hand, and is slow to take up new notions unless it be in way of adornment. Then we must look around for some manner in which she can operate her machine without injury to her health, and yet retain the same machine and chair; which brings me to the third and last method, namely, the *position* which the operator occupies at the machine.

Many of our manufacturers advertise their machines with pictures of girls of tender years operating them with apparent ease, the same little girls having exceptionally round cheeks, bright eyes and rounded arms, leaving the inference to be drawn that their particular machine runs so easily that even a little girl can retain her usual health in operating it. And there is no reason why this should not be true. A new machine, well oiled, will, as a rule, almost run itself, and hence requires but little power.

Every woman whom it has been my privilege to see operating a machine, and my opportunities in this direction have been ample, invariably uses both feet to propel it, giving as an excuse that the machine runs so hard as to require that much force. We have endeavored to show that if properly cared for a machine can be run with very little power. I will go further, and say that the machine which cannot be run with one foot by any woman in average health, is not fit to be run at all. We will suppose a woman seated at the machine, one foot on the treadles the other on the floor, the knees apart, the adductors at rest, the abdomen not pressed unduly upon, the generative organs neither irritated nor disarranged, the machine running so easily that over-exertion of the muscles is at a minimum, and we have a condition of things which will allow her to sit in a common chair and operate the present sewing machine with comparatively little detriment to her health. I am not stating a supposition, but a fact which has stood the test of thorough trial, when I say that if a woman will use one foot to propel the sewing-machine, and alternate the foot as occasion requires, very many of the irritative diseases incident to her sex would be abated. I also am convinced, that when running the machine no corset should be tolerated, as the loosest corset is too tight when using the lower extremities in a sitting posture.

A THOUGHT ON THE DESTINY OF ALCOHOL IN THE BODY.

BY THOS. J. MAYS, M.D.,
PROFESSOR OF DISEASES OF THE CHEST IN THE PHILADELPHIA POLYCLINIC.

I do not believe that the fact that a large amount of alcohol can be taken under certain circumstances without producing the least intoxication, has ever escaped the attention of the observant physician. For example, a person who is extremely sensitive to the narcotic effects of alcohol, i. e., one in whom a half teaspoonful dose of brandy will produce the characteristic symptoms of narcosis, such as weakness in the legs, flushing of the face, etc., receives a severe shock, as from an injury, and may then be able to take the same preparation in two or three tablespoonful doses without experiencing the slightest inebriation, but on the contrary will be materially benefitted by it. Or, take a case of croupous pneumonia. In this disease it is well-known that at, or about the period of crisis, alcoholic liquors can be literally poured down the throat of the sufferer without producing any intoxication whatever. I have known such cases where more than a quart of the best brandy was consumed in less than twenty-four hours with nothing but what was believed to be the very best results. There are also records of many cases of snake-bites in which phenomenally large quantities of brandy and whiskey were administered and apparently without any alcoholic symptoms.

Now what becomes of alcohol in such enormous doses? We think this agent is entirely anomalous in this respect, as well as in its action. It is true that in cases of idiosyncrasy, or in tetanus and acute mania, the poison line of morphine is somewhat widened, but in no instance can it be given *ad libitum* like alcohol. Strychnine, atropine, curare, veratrum viride, cocaine, digitalis, and most other vegetable alkaloids must be given in reduced doses so soon as they begin to exert their physiological effects. The large doses in which morphine, and several other drugs are tolerated, can be explained by the well-known physiological law, that a nerve when intensely irritated or exhausted from any cause is less impressible to incidental forces than a healthy nerve. The action of morphine is, however, fundamentally different from that of alcohol, inasmuch as it undergoes no change in the body, and therefore acts by its presence, or through its mechanical influence; while on the other hand it is positively established that alcohol is decom-

posed by the animal economy, and therefore has a chemical action.

From a clinical standpoint, therefore, the only rational explanation which can be given of this singular behavior of alcohol is, that it furnishes some force to the body which is utilized in the same manner as food force is. During great prostration, or extreme depression, just as in pressing hunger, the demand for this force is great and urgent, but in ordinary health it is small and can probably be best supplied by food. Unless this extraordinary action of alcohol can be accounted for on other grounds by our abstemious friends, we think there is much reason for the belief that it has no other but a food action.

Society Reports.

NEW YORK ACADEMY OF MEDICINE.

Stated Meeting, March 1, 1888.

The President, A. Jacobi, M.D., in the chair.

Should We Treat Syphilis During the Primary Stages.

Dr. Edward B. Bronson read the first scientific paper of the evening, bearing the above title. He explained that by the term preventive treatment was not necessarily meant abortive treatment, but all measures, which in any degree abridged the course of the disease and ameliorated its effects upon the constitution. He showed that in as much as we do not know the essential nature of syphilis, and we have no radical treatment, we must, in looking for new and more effective means of combating it, be guided to some extent by theoretical considerations. He asked the question, if the indications thus far afforded by our imperfect knowledge of syphilis were such as to render any form of preventive treatment in the primary stage unavailing and absolutely hopeless; for such was the view entertained by many physicians. There were two ways of approaching this question, the one theoretical and the other empirical.

No theory explained syphilis so satisfactorily as that which attributed it to the presence and growth in the tissues of a specific micro-organism. But if this theory could be established, it would by no means make certain that preventive methods would prove successful.

Dr. Bronson thought theory and facts pointed to a temporary sojourn of the syphilitic virus in the region where it was first implanted, and during that period the disease was local, not constitutional. From here it sooner or later contaminated the neighboring lymphatic glands, and then passed to the general system. The author cited some objections which had been raised to this view, which he thought were without foundation, and then proceeded to show the inefficacy of proposed methods of treatment during the primary stage of the affection. The principal measures proposed had been excision and cauterization of the initial lesion. Briefly reviewing the history of these measures, he came to the conclusion, as many other distinguished syphilographers had done, that they had not been successful, and that in the nature of things they could not be. The basis for this opinion was the fact that the disease had become general, or affected glands which would escape the surgeon's knife or cautery, before the development of the initial lesion, or the time at which the treatment could be instituted.

He then spoke of the objections which had been offered against general medication during the primary stage. The chief one had been that it was indirect, for, as long as the affection remained local, it was extremely doubtful whether medicine taken internally would reach and destroy the localized virus. The author reasoned that the remedy so much relied upon in the general treatment of syphilis would be more likely to prove a germicide to the syphilitic micro-organism if applied locally during the primary stage than if it were to act by passing through the general system. This view was based on theoretical grounds, and on such grounds he commended it to the consideration of those who had occasion to treat this disease.

The method of employing the drug (mercury) was both by inunctions and by hypodermic injections into the glands in the neighborhood of the initial sore. The injections consisted of not more than one one-hundredth of a grain. He preferred mercurial soap to mercurial ointment for rubbing into the skin. It might be said that this regional treatment was also constitutional treatment, as in a degree it was, but it was something more. Better this, the author thought, than to let the case go on without lending the patient any possible hope. While the treatment was recommended on theoretical grounds, yet he had employed it in certain cases, although the diagnosis and method of applying the treatment were so uncertain as not to justify any conclusions.

Dr. E. L. Keyes said he would have been much interested to hear the results of experiments with this form of treatment. In general he was opposed to constitutional treatment during the primary stage of syphilis for the reason that it rendered its after progress irregular. Excision and cauterization had, he believed, failed in every instance to cut short the disease, and he doubted whether this local treatment with mercury would prove more effectual. The virus had entered the general system before it could be reached by local measures.

Dr. R. W. Taylor held the same views as Dr. Keyes, that general treatment during the primary stage of syphilis was objectionable, as it rendered the future progress of syphilis irregular; the diagnosis remained uncertain until the secondary lesions presented, and if by constitutional treatment during the primary stage such secondary lesions were averted, the patient would not feel convinced that he had syphilis, and would prove intractable; yet the tertiary symptoms were as likely to develop in all their severity as if the disease had taken its usual course, producing the eruption, etc., of the secondary stage. He believed that syphilis was at first a local affection, but he doubted the efficacy of such proposed local treatment. Certainly excision and cauterization had, in his opinion, failed to abort a single case. Then he thought injections of mercurial solution in the glands on the thigh would, if the solution were of sufficient strength to be efficacious as a germicide, produce ulcers. Such had been his experience.

The President compared syphilis with infectious diseases regarding which more was known, particularly diphtheria, and thought a lesson might be learned therefrom. In diphtheria the poison might be local, and it might enter the general system and cause a constitutional disease; it usually entered by way of the lymphatics, but it sometimes found its way to the general circulation directly through the blood-vessels in the neighborhood of the local disease.

A paper by Mr. Bernard Roth, F.R.C.S.E., on

The Treatment of Flat-Foot,

was read by Dr. V. P. Gibney. The author said he was glad to comply with Dr. Gibney's request to contribute to a symposium on this subject, and the more so because his views had changed in some particulars since he wrote an article on flat-foot in Heath's Dictionary of Practical Surgery two years ago. The term flat-foot was a broad one; the cases should be classified clinically if surgeons would come to an agreement regarding treatment. Mr. Roth divided the cases into three classes: 1. Those in which it was possible to restore the foot to the normal situation without mechanical or operative measures. 2. Those in which the foot had become so fixed in its abnormal position by shortened ligaments and tendons, and changes in the articulating surfaces, that it could not be restored without operative measures or *brisement forcé*. 3. Intermediate cases, in which partial restoration of the tarsal arch was possible without *brisement forcé*.

The author had observed that all infants had flat-foot, but when they stood and ran about a few months the arch developed with the development of the muscles on the anterior aspect of the leg. He always assured anxious mothers that there was no cause for their fears in these cases. He believed with Mr. Thomas that the muscles acting upon the foot had their insertions favorable for the support and development of the tarsal arch. Anything which tended to weaken those muscles predisposed to flat-foot. Flat-foot was often associated with knock-knee, and was liable to occur when an injury to one leg caused most of the weight of the body to be thrown upon the other.

In the treatment of the deformity the surgeon had in mind the restoration of the depressed arch, and the development of the muscles which tended to form and sustain that arch. Practically the treatment resolved itself into mechanical and surgical measures for restoring and sustaining the arch, and into therapeutic means for strengthening the muscles.

Regarding mechanical measures, the author said that during the last eighteen months he had discarded pads, and he no longer insisted on wearing a laced boot. He had the shoe made to fit the foot, and the sole and heel so shaped as to direct the axis of the tibia toward the outer aspect of the foot. His reason for doing this was founded on Mr. Thomas's explanation of the formation of the arch, which he believed to be the true explanation, namely, that the weight of the body transmitted through the tibia was expended upon the inner aspect of the arch, and that the arch was enabled to retain its shape by the action of the muscles; when the muscles became weakened, the weight of the body being transmitted through the tibia to the inner aspect of the arch, that arch broke down, and the patient walked upon the inside of the foot. A quarter to half an inch was added to the inner margin of the heel and sole. In the second class of cases *brisement*

forcé should be resorted to preferably according to Thomas's method, and then the cases should be treated as in class one.

The author then described methods for developing the muscles of the leg going to support the arch, consisting in passive and active gymnastic exercises, including walking on the toes a short distance, say fifty feet, after each meal.

The paper was discussed by Drs. Ridlon and Phelps.

The Tariff on Medicines and Surgical Instruments.

A resolution was passed petitioning Congress to remove the import duty on medicines, surgical instruments and apparatus.

Reports of Clinics.

HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA.

GYNECOLOGICAL CLINIC—PROF. GOODELL.

Ovarian Tumor.

This woman is 43 years old. I need not call your attention to the enormous tumor from which she seeks relief at our hands. The history of her trouble dates back a period of four years. She first noticed occasional cramps occurring in the lower part of the abdomen, and these were soon accompanied by abdominal swelling. She has not seen her menses for three years. She has lost flesh, her face has become wrinkled and wears a pinched expression, which experience will teach you is strongly suggestive of ovarian disturbance. She has been tapped six times in all, between eight and nine gallons of fluid being withdrawn at each operation.

Let us examine the tumor together. The abdomen is enormously distended, and dilated veins may be traced over its entire surface. On palpation we find fluctuation unusually well defined, and dulness on percussion until we reach a point about three inches above the umbilicus. Here it is resonant all the way up to the ensiform cartilage. Below this is an apparently solid tumor, which gives the sense of ballottement; that is to say, it yields before the finger, as if floating in a fluid, and then returns to the finger with a slight tap. This means that, apart from the tumor, ascitic fluid is present. On transferring our attention to the vulva, we find the vagina completely everted, distended by the ascitic fluid, and exhibiting in consequence an appearance not unlike the male scrotum. In the centre of it is the os uteri, into which I pass the sound fully five inches, showing hypertrophic enlongation of the womb.

Now we are ready to make a diagnosis, and we pronounce the tumor to be ovarian for the following reasons: 1st. The patient has not menstruated for three years, and this fact may additionally be regarded as strong evidence that both ovaries are involved. 2d. The swelling began within the pelvic cavity and extended upwards, lifting the intestines as it advanced. 3d. Ovarian tumors are those of most common occurrence. 4th. It is not a fibroid, because, among other reasons, the menses have ceased here, while the development of a fibroid would have made them more profuse.

Is the tumor malignant? The facts that it began with considerable pain, that we have ascites present, and that both ovaries are involved, might justify us in so thinking. There are some arguments, however, opposed to this supposition. In the first place, the history of the woman's condition covers a period of four years, which is much longer than the usual history of a malignant growth. (It might, however, be a sarcoma, these tumors being sometimes comparatively slow in their progress). Again, the ascites, which is here present, may have proceeded from a papilloma. Very often these cauliflower-like excrescences push their way into the peritoneal sac through the wall of an ovarian cyst, and secrete a prodigious amount of fluid. I shall operate on this patient within the next few days. *

Nervous Abdominal Pulsation Simulating Aneurism.

This patient has just presented herself. In answer to my question as to why she comes to us, she places her hand over the region of her stomach and says that she has a constant throbbing and pulsation there, which has been

*This woman was operated upon a few days later before a ward class. The tumor proved to be a proliferous cyst of the right ovary, with omental adhesions. It was surgically a solid tumor, and could not be reduced in size, even by breaking up the thousands of daughter cysts contained within it. The incision, therefore, had to be a long one, needing twenty-four sutures to close it. The parietal peritoneum was greatly thickened, and the ascitic fluid very abundant. The emptied cyst weighed sixteen pounds; the fluid from it and from he abdominal cavity together weighed eighty-three pounds; the total weight being ninety-nine pounds. A drainage tube was put in, which was removed in forty-eight hours. Since the operation the patient has done well, the temperature reaching just 100° only once.

called an aneurism by several physicians. I am glad to be able to examine this case with you, for it is one of a class that often proves very puzzling. A number of cases are sent to me each year presenting many symptoms which, at first glance, are strongly suggestive of abdominal aneurism. They are almost invariably women of the nervous diathesis, sensitive and highly emotional.

This woman is 24 years old, single, and a domestic servant. She has felt her present sensations for something over two years. At first her symptoms were chiefly those produced by an ordinary dyspepsia, but, in time, these were accompanied by the throbbing which she now complains of and which gradually become more noticeable and more annoying. At present her appetite is fair, but the process of digestion is somewhat painful, and is accompanied by frequent regurgitation of the gastric contents. Flatulence exists, and her bowels are very costive. Her menstrual periods are regular, but the flow is scant and is always attended by pain, and she is very nervous. We find the uterus retroverted, slightly flexed, and giving a measurement of plus three inches. This increase is due to the long-standing retroversion and its consequent dysmenorrhœa. The womb being practically turned up-side down has become gorged with blood and has undergone a gradual hypertrophy. On examining the epigastric region in which lies her chief source of discomfort, we find what seems to be a pulsating tumor. It gives a tense, hard feeling to the hand, which rises under it with every stroke of the heart, as all of you can plainly see for yourselves. I cannot, however, detect any thrill. Now, gentlemen, I do not believe that this is an aneurism, in fact, I am confident it is not. In examining cases like this you will frequently find the rectus muscle a great obstacle in your way and very often the cause of your falling into error. Many women involuntarily contract this muscle at the moment of examination, and throw it into such a rigid condition that it gives to the touch the sense of a tumor, and seriously interferes with any manipulation of the viscera beneath it. At the same time, while the hand is lying on it, it will rise and fall in response to each impulse of the underlying aorta, and will so lead an incautious diagnostician into believing in the existence of an abdominal aneurism. An aneurism, however, would be accompanied by pain, it would be likely to increase steadily in size, and would convey to the hand that peculiar thrill which we fail to find here. Moreover, it is to be remembered that in some women aneurisms are extremely uncommon. If I should etherize this patient the rectus would relax and so remove any uncertainty of diagnosis at once, but I can obtain this same result in a less direct way. Just as a conjurer fires off his pistol to distract the attention of his audience away from his trick, so I shall fire off my pistol, but in another way. I distract the woman's attention from everything else by making a uterine examination, and while doing this with my left hand, my right, unnoticed by the patient, is placed upon the now relaxed rectus muscle and is pressed close down upon the aorta. This vessel throughout its abdominal course, is found of uniform calibre and quite free from any aneurismal dilatation.

Now, what shall we do for this woman? In the first place she shall have a laxative pill, and a very excellent combination for this purpose is found in the pil. aloinæ, belladonnæ, and strychniæ, which is kept in stock by most druggists. The laxative spring waters may be of temporary benefit in cases of habitual constipation such as this, but they soon loose their effect, and the quantity taken has to be increased. This pill which I recommend to you, however, restores tone and energy to the paretic muscular layer of the intestinal walls, and, so far from having to be increased, may gradually be reduced in frequency of administration, and finally stopped altogether. In addition I shall put her on the following mixture, which will act as a general systemic tonic, and coincidently, as a nervous sedative:

℞ Tr. digitalis..... .....f℥iiss
Ammon. chlorid.....℥ij
Ammon. bromid..... ..ʒss
Infus. gentian..... .....ad f℥vj
M. S.—Dessertspoonful t.i.d.

—In a paper read before the Gynecological Section at the Sixtieth Congress of German Naturalists and Physicians, Wiedov (*Annales de Gynécologie*, January, 1888) reported five cases of albuminuria in women, in which he demonstrated that the placenta presented the lesions which have been already noted by Fehling. These lesions consist in infarcts, which are to be met with both upon the fœtal and maternal surfaces of the placenta. Fehling stated that in 800 pregnant women he had found eighteen who had albumin in their urine. In all of these cases the placenta presented more or less numerous characteristic white infarcts. As to their origin, Fehling agrees with the opinion of Scanzoni, that in a large number of the cases they are the result of hemorrhage.

Periscope.

Treatment of Intussusception Without Operation.

In the *Brooklyn Medical Journal*, February, 1888, Dr. G. R. Butler reports a case of intussusception which was relieved by hydrostatic pressure. The patient was a little girl three years old, who had suffered for ten days from slight bronchitis and constipation. The latter had been easily relieved with common domestic remedies until thirty-six hours before Dr. Butler's visit. The bowels were then obstinately constipated. During the thirty-six hours nearly three bottles of the ordinary solution of magnesium citrate had been given without result, except that they caused tenesmus and discharges of mucus with small amount of feces. The stools contained no blood. Paroxysmal abdominal pain had occurred, gradually increasing in severity. Vomiting began twenty-four hours previously, and at the time of his visit the ejected matter had a slight fecal odor. The child had eaten nothing, the face was pale and had an anxious look, skin cool and moist, pulse accelerated, temperature 99°. The abdomen was distended and tympanitic, with a special point of tenderness to the left of, and on a level with, the umbilicus. At this point there was a sense of resistance on palpation. It was not possible to accurately outline a tumor.

The child was placed across its mother's lap and the nates elevated. A soft catheter attached to a fountain syringe was then introduced four or five inches into the rectum, meeting with no opposition. Tepid water was slowly injected until the bowel was thought to be distended to the point of safety. Some of the fluid escaped by the side of the tube, but about thirty-five ounces probably entered. The child was then placed upon the left side, with the hips elevated by a pillow. The enema was retained, and the child soon fell asleep, and slept six hours. On awaking, it passed the injected fluid with a moderate amount of fecal matter. Pain and vomiting had ceased. It rested quietly during the night. The next morning a natural and copious movement of the bowels occurred without pain. The child had regained its normal appearance and spirits. No further trouble of any kind was experienced.

In the *Lancet*, Feb. 18, 1888, Dr. Cheadle reports a case of intussusception which occurred in a slightly rickety infant fifteen months old. In this case the child vomited several times, and the passage of blood from the bowel was a frequent and prominent symptom. A tumor was unmistakably outlined by rectal examination. There was much pain and great straining. The rectum was gradually distended by inflating it with air from a Higginson's syringe, and the tumor manipulated through the abdominal walls. Recovery followed. Dr. Cheadle says that this is his third successive case in which the intussusception has been reduced by inflation, and that Dr. Barlow has had a fourth. Early diagnosis and prompt employment of the inflation are the essentials to success.

In the *Lancet*, February 25, 1888, Dr. Goodhart reports still another case, occurring in a child eight months old, in which reduction of the intussusception was effected by means of an enema of two pints of warm boracid acid solution, five grains to the ounce, which was injected with Lund's apparatus. In this case the child suffered with convulsions; the stools were bloody, but the blood was not admixed with mucus, and was not frothy. A sausage shaped tumor could be outlined.

Poisoning with Antipyrine.

In the *Lancet*, February 25, 1888, Dr. Oscar Jennings reports a case of poisoning with antipyrine. The patient was a woman 67 years old, who was of gouty ancestry and suffered with swelling of the hands, without positive pain, but with sensations of pricking, which interfered somewhat with the use of the hands. She was given 37½ grains of antipyrine a day for eight days, when the skin of her arms became covered with erythematous patches; her eyes at the same time became uncomfortable. The following night she scarcely slept at all; the feet were icy cold; there was no nausea, and no giddiness. The next day her face was red and extraordinarily swollen, so as to almost close the eyes, just leaving a narrow slit for vision. The rash was general and of the color of pomegranate, and was arranged in patches the size of a three-penny piece, separated from each other by slight but distinct intervals. The condition gave rise to no suffering, there was only slight itching, but the patient felt as if "the inside of the body was filled with ice." There was irritation of the nasal fossæ and hoarseness of the voice; the pulse was twice as fast as usual but the temperature was lowered. There was slight buzzing in the ears. The symptoms gradually disappeared, but the patient still suffers from considerable prostration and sensations of cold.

Dr. Jennings says that, since encountering the case just cited, the following have been

related to him: Mrs. Y., was treated with antipyrine in order to be *radically* cured of rheumatic pains. She was ordered 75 grains a day. "'The second day," writes Miss X., "my friends went to see this lady, who is one of the most intelligent, one of the most witty, and one of the most charming women in Paris. They found her with her head between her hands, the elbows resting upon the knees, rocking backwards and forwards, repeating incessantly, 'I don't know what is the matter with me; I remember nothing; I am becoming like an idiot; I am going mad.' She was subsequently confined to her bed with severe gastro-enteritis for six weeks, and kept her room for three months. Lately she has improved, and has recovered her lost intelligence.

Mrs. Z. was treated with antipyrine. "Her body swelled, as did also the inside of the throat, which was obstructed to such an extent that for six hours she was threatened with suffocation. The skin was covered with red spots, without itching, and the perspiration dripped off the extremities of the fingers."

Transplantation of the Cornea.

In a further communication upon transplantation of the cornea, which is contained in the Report of the Ophthalmological Society of Heidelberg, 1887, S. 30, Von Hippel states that he has succeeded in two cases of leucoma of the cornea in which Descemet's membrane was not opaque, in transplanting the rabbit's cornea upon the human eye. By means of a specially constructed knife the central leucoma upon the patient's cornea was excised in a section of 4 min. (.159 inch) diameter down to Descemet's membrane. A segment of the same size taken from the rabbit's cornea was then transplanted upon the patient's eye, and these united immediately and remained transparent. This patient who before could count fingers only at a distance of 6½ feet, now has a vision of $\frac{20}{200}$. Up to the present time, one year and nine months after the operation, the transplanted segment has not become cloudy. A gray reflex is returned upon focal illumination, but this is brought about by the different index of refraction of the rabbit's cornea and the most posterior layers of the human cornea, which were left behind; at the surface of junction of the two, the light is strongly reflected.

In the second case, in which a serpiginous ulcer had been followed by a central leucoma, a piece of cornea was transplanted in the same way. This also united and remained transparent. Vision had risen to $\frac{1}{10}$. —*Centralblatt f.d. med. Wissensch.*, January 28, 1888.

Syrup of Tar in Winter Cough.

In the *British Med. Journal*, March 3, 1888, Dr. William Murrell says that tar is undoubtedly one of the best remedies for chronic bronchitis and winter cough. He uses the syrupus picis liquidæ of the U. S. Pharmacopœia. With the addition of a few drops of ammonia or other alkali the syrup can be prepared of almost any desired strength of tar. He usually gives it in doses of from two to four drachms every three hours, or even oftener. If disagreeable to take, it may be flavored with syrup of wild cherry. The efficacy of the combination may be greatly increased by the addition of a little apomorphine. Six minims of a two per cent. solution may, he says, be given frequently without exciting nausea. During the past two years he has used this method of treatment in nearly a hundred cases of chronic bronchitis and winter cough, and has every reason to be satisfied with the result. The cough is relieved, expectoration is rendered easier, and the patient usually sleeps well at night. The syrup of tar alone without the apomorphine is admirably adapted to the treatment of the coughs and colds of children, and has none of the disadvantages of preparations containing opiates.

Guiacol in Phthisis.

At a meeting of the Society for Internal Medicine, of Berlin, February 6, 1888, Dr. Fraentzel made some remarks upon the use of guiacol in phthisis. He coincides with the opinion previously expressed to him by Dr. Penzoldt, of Erlangen, that guiacol is the active constituent of creasote; and he employs it in the same doses in which he gave the latter. He uses a formula which is approximately represented by the following mixture:

Guiacol	f℥j
Tinct. gentianæ	f℥ij
Alcoholis	f℥j ♏clx
Vini Xerici (Sherry) q. s. ad	f℥v

M. Sig.—Take a teaspoonful two or three times a day in a wineglassful of water.

Fraentzel thinks the drug is better borne by the stomach when given in this mixture than when given in capsules or with syrup of tolu. Although his experience with it is as yet limited, he advises its employment in preference to creasote.—*Deutsche med. Wochenschrift*, Feb. 16, 1888.

Sequel to a Case of Ligature of the Carotid.

At a meeting of the Clinical Society of London, Feb. 24, 1888, Mr. Holmes read some notes which formed the sequel to an old case of ligature of the carotid artery, which was published in the ninth and tenth volumes of the Society's Transactions as one of distal ligature of the left carotid for aortic aneurism. The patient survived the operation for twelve years, and then died of phthisis. The *post-mortem* examination proved that the thrill, bruit, and pulsation, which were thought to be caused by aneurism of the aorta, depended on stenosis of the valves of the pulmonary artery, with dilatation of its left branch. There had been weakness and occasionally total absence of pulse in the left arm, but the cause of this was not explained by the autopsy, which had been somewhat hurriedly made. The aorta and its branches were healthy as far as they were examined. The left carotid was obliterated in its whole extent. As the case had been used in discussing the propriety of distal ligature in aortic aneurisms, it was thought right to publish this correction.—*Lancet*, March 3, 1888.

Hydrobromate of Hyoscine in Acute Mania.

In the *Lancet*, Feb. 4, 1888, Dr. George Thompson, Medical Superintendent of the Bristol Asylum, England, reports three cases of mania which were successfully treated with the hydrobromate of hyoscine. In each case the wildness or restlessness was calmed, and what is more noteworthy, the attack cut short and its recurrence rendered less frequent. The author remarks that in mania of any form the drug is the best calmative which has yet come to his notice. In some cases of general paralysis attended with dry skin and some suppression of urine, a small dose puts the patient in a much more comfortable state.

Intermittent Albuminuria.

Much has been written lately upon intermittent albuminuria. In some cases food and in others exercise seems to be the determining factor in its production. In a communication in the *Lancet*, January 7, 1888, Dr. George Johnson, who is well known for his studies upon the urine, reports two cases which illustrate the influence of food and exercise in the production of intermittent albuminuria. He states that his main object in this communication is to insist upon the practical importance of testing the urine in all cases at frequent intervals during the twenty-four hours, in order to ascertain the exciting cause of the albuminuria, and so to adopt measures to avoid or counteract it. He regards a saturated solution of prussic acid as the most delicate and trustworthy test for albumin with which he is acquainted. Any precipitate except albumin will disappear upon the application of heat below the boiling point.

He regards the term cyclical albuminuria as misleading, for it seems to imply that the abnormal condition occurs (like a tertian ague, for instance), in a regular cycle, without reference to external, ascertainable, and avoidable influences. He holds that while a treatment based upon a careful observation of the existing causes of the condition is usually successful, yet, on the other hand, it is unquestionable that however free from other symptoms of disordered health the subject of this condition may be, a frequently recurring albuminuria, if neglected, will almost invariably result, though it may be after many years, in structural degeneration of the kidneys. In one case which came under his observation, a period of thirty years intervened between the onset of this condition in connection with scarlet fever, and the fatal termination. An indiscriminate prophecy of smooth things in this class of cases may for the time be pleasing to the patient, but if this leads to the neglect of needful precautions the ultimate result will be disastrous. He denies the existence of physiological albuminuria, unless by that is meant a condition in which albuminuria exists, but with no other symptom of disordered health; in which case the greatest possible amount of albumin in the urine might in many cases be designated as physiological.

Cytisine in Migraine.

Cytisine, the name given to a very poisonous alkaloid extracted from the seeds of *cytisus laburnum*, gold rain, has the effect of narrowing the blood-vessels. The possession of this property induced Professor Kraepelin to employ it in the so-called paralytic form of migraine, and he has obtained brilliant results in two cases, which he has published in the *Neurologische Centralblatt*, No. 1. The first case was that of a young woman, 21 years old, who suffered every two or three months with violent attacks of right-sided headache. The attacks, which for the most part developed toward evening, were preceded regularly by great restlessness, a feeling of oppression, pain in the cardiac region, nausea, a redness of the right side of the face occurring in spots, and strong pulsation of the right temporal artery. After one or two hours, headache, affecting

the entire right side of the skull, began, and was accompanied with violent vomiting, anxiety, absolute loss of sleep, dread of light, and the dancing of bright specks before the eyes. The attack lasted from twelve to twenty-four hours, and was succeeded by great weakness, marked dilatation of the right pupil, and disturbance of sight of the right eye.

After various remedies had proved ineffective, Kraepelin tried at the beginning of the attack 1-22 of a grain of nitrate of cytisine by hypodermic injection. The result was surprising. In the course of half an hour the redness disappeared, and also the feeling of oppression and the pain. The same result was obtained with the greatest regularity in every one of the numerous attacks under an increase of the dose to 1-13 of a grain in the course of the following months. The drug was most active when employed at the earliest possible moment.

The second case was that of an hysterical medical student, who had suffered from his youth with violent attacks of migraine, which lasted twelve hours. Fifteen minutes after the injection of 1-22 of a grain of cytisine, the pain subsided, and in half an hour he was entirely recovered. — *Wiener med. Presse*, Feb. 5, 1888.

Preparations of Extra-uterine Pregnancies.

Mr. Lawson Tait exhibited recently, at Birmingham (*Brit. Med. Journal*, Jan. 7, 1888), a series of specimens of extra-uterine pregnancy in all stages of its development, from the earliest known case of tubal rupture, which apparently had occurred between the third and fourth week, up to a section of a cadaver at full term. The interest of these cases lay chiefly in the fact that they completely established the view as to the pathology of extra-uterine pregnancy which Mr. Tait had first published in 1873: that all extra-uterine pregnancies were due to the impregnation of the fertilized ovum on the denuded wall of the Fallopian tube; that the tube was distended up to its bursting point, which generally was from the tenth to the thirteenth week. The condition of the subsequent pregnancy depended entirely upon the point at which that rupture took place. If the rupture was into the peritoneal cavity, then death took place from hemorrhage; and twelve of the specimens shown were illustrations of this. If, on the contrary, the rupture took place into the cavity of the broad ligament, the hemorrhage was slight, and the pregnancy might go on to full term. Many of these cases, however, did not go to the full term; the fœtus died, and was thrown off by suppuration through the bladder, rectum, or into the vagina, or ended in the formation of a lithopædion. A few well recognized examples of these are to be found in almost any museum. The minority of cases went on with the child living to full term, and could be operated upon. Mr. Tait had operated seven times under such circumstances. That the danger of rupture into the peritoneum is great was shown by the case of early rupture alluded to, in which the patient was well at two o'clock in the afternoon, and was dead from hemorrhage from a small point of rupture in the tube at nine o'clock at night. In occasional instances, if rupture took place into the abdominal cavity, the placenta was separated from the tube and obtained new attachments. As one example, he showed a preparation from a patient in Nottingham— to which town Mr. Tait was summoned to perform abdominal section on account of the condition of ruptured tubal pregnancy, which had been previously recognized. He opened the abdomen, removed the fœtus, the placenta, and stump of the tube, and tied the latter. As soon as this was done the brisk hemorrhage ceased, and a part of the placenta which had become implanted on the intestine at the back of the uterus was removed, and the sites of it smeared over with solid perchloride of iron. The patient had made a perfect recovery.

Cocaine in Glaucoma.

Dr. Barrenechea reports to the *Revista medica de Chile* his experiences based upon personal observations of the use of cocaine in glaucoma. They are covered by the following propositions (*Deutsche Medizinal-Zeitung*, October 27, 1887): 1. The employment of cocaine in glaucoma produces only an anæsthesia of the conjunctiva. 2. In simple chronic glaucoma cocaine has no action. 3. The application of cocaine in chronic irritative glaucoma must be undertaken either in conjunction with pilocarpine or eserine, or some minutes before the use of these drugs. 4. If used alone in this case cocaine can give rise to an acute attack. 5. After the performance of an iridectomy in glaucoma, it is useful to employ cocaine in the combination just mentioned if pain in the ciliary region occur as a result of the irritation of the nerves. 6. Cocaine acts in glaucoma by promoting the circulation, and calling forth a greater and more permanent effect of the antiglaucomatous drugs named.

Contribution to the Etiology of Syphilitic Dactylitis.

In a paper on this subject in the *Archiv für klin. Chirurgie*, xxxvi, 1887, p. 356, Dr. Franz Eschle, of Hamburg, sums up his conclusions from his reported cases as follows:

1. Not only gummatous new formations in the medulla of the bones of the fingers and periosteum lead to the changes comprised under the name syphilitic dactylitis, but also gummata arising in the soft parts through indirect implication of the former tissues.

2. Nothing contradicts, in his cases, the assertion of Lewin that in children the osteomyelitic, in adults the periosteal form, of dactylitis predominates.

3. In syphilis (only congenital?), hereditary influences may play an important part in the predilection for a certain form of symptoms and their localization.

4. Dactylitis seems to affect especially those who are run down and badly nourished, and those who have a tendency to scrofula or tuberculosis.

5. The prognosis is bad. The obstinacy of the affection may lead to disability, with loss of the finger. It occasionally indicates so grave a form of syphilis that other complications arise which endanger the life of the patient.

Strophanthus Hispidus in Heart Disease.

Dr. Leon Rosenbusch has employed strophanthus in a number of cases, and sums up the results of his observations in the following propositions (*Berliner klin. Wochenschrift*, Feb. 13, 1888):

1. It has a marked action upon the heart, increasing the power of its systole, lengthening the systole, increasing the arterial tension and slowing the heart's action. 2. It strengthens the heart-muscle and regulates the work of the heart. 3. It acts as a diuretic in diseases of the heart, but in diseases of the kidneys its diuretic action is very slight. 4. It does not disturb digestion as other heart poisons do, especially digitalis. 5. It may be employed for weeks without giving rise to cumulative action. 6. It is best employed in the form of a pure tincture, in doses of 10 to 20 drops, three times a day. 7. It is less vigorous in its action than digitalis, and is therefore indicated especially in those cases in which digitalis has not yet been tested. 8. It maintains, especially in severe disturbances of compensation, the effect of digitalis which has been previously administered. 9. The alcoholic tincture should be employed. This contains the whole of the bitter glucoside, while the ethereal tincture may disturb digestion. 10. In stenosis of the aortic valves its action is negative, as it lengthens still more the systole; it should not be employed in this disease.

Care of the Eyes of School Children.

A very sensible decree has just been issued by the Austrian Minister of Public Instruction forbidding the use of books printed with small type in public schools, as short-sightedness is so prevalent amongst school children in Austria. The *Lancet* remarks that scientific supervision might very properly be given to school books in England, attention being especially directed to the size of the type, length of line, and spacing of letters and lines. In the works published by the Clarendon Press, the same journal thinks that no fault can be found in the respects just mentioned. The chief fault in German books is said to be their adherence to the very dazzling Old English shape of the letters, which certainly severely tries the eyes, in that it necessitates very close attention. The evil effect of this is heightened when the paper is coarse, and when the paper is read by insufficient light.

Effect of Food upon the Composition and Nutritive Activity of Mother's Milk.

Dr. St. S. Zaleski, of Dorpat, Russia, concludes a series of papers upon the effect of food on the composition and nutritive activity of mother's milk (*Berliner klin. Wochenschrift*, Jan. 30, 1888), by the following propositions:

1. Mother's milk, very rich in fat, can of itself exercise a positively injurious influence upon the well-being of the child.

2. A luxurious diet, consisting exclusively of food very rich in albumen increases considerably the quantity of fat in mother's milk, diminishes the sugar of milk, but is of less influence upon the other constituents. Alcoholic beverages have a similar effect.

3. The desirable, and for the child in special cases, indispensible composition of the milk, may be attained through suitable diet and nourishment of the mother.

4. In women the effect of food upon the composition of the milk seems to be the same as it is in animals.

5. The fat of the milk is in all probability formed, in a direct or indirect way, out of the albumen-containing the foods.

The Conditions conducive to the Earliest Possible Healing of Operation-Wounds.

In a paper read before the Surgical Section of the New York Academy of Medicine (*Med. Record*, Jan. 28, 1888, Dr. W. W. Keen stated these conditions to be as follows:

1. The use of the antiseptic method before and during the operation, and at the later dressings.
2. Thorough drainage.
3. Complete approximation both of the edges and raw surfaces.
4. The use of antiseptic dressings.
5. Securing absolute rest during the period of repair.

Brain Surgery in Dublin.

At a meeting of the Surgical Section of the Royal Academy of Medicine, in Ireland, March 2, 1888, three successful cases of trephining were reported and the discussion upon the papers was adjourned to a future night. These cases were all remarkable. Professor Thornley Stoker read particulars of a case in which a man fell from a cart while drunk. He came to the Richmond Hospital some days later, rather stupid, and with some lightly-marked paralytic symptoms. It was not easy to determine that he had not had an attack of apoplexy. The paralysis becoming more marked, Mr. Stoker trephined in the region of the fissure of Rolando—there was no fracture—and struck the margin of a blood clot. He again trephined and more fully exposed the clot, which was washed out. The area so compressed was about three inches, and the clot measured nearly an inch in depth. The patient recovered and was exhibited. Sir W. Stokes read a paper on a case of successful trephining for cerebral abscess, and exhibited his patient. The man had been struck with a poker on the left side of the mesial line of the head, about an inch anterior to the coronal suture. He was treated as an out-patient at another hospital, but ultimately applied at the Richmond, when he was admitted, several weeks having elapsed from the date of the injury. He soon presented brain symptoms, became convulsed and comatose, and it was determined to trephine. A small fracture was found under the scar; the dura mater bulging into the wound, an exploring needle was introduced to the depth of an inch and a half, and pus at last found. The dura mater was then incised, and one ounce and a half of pus was evacuated. The patient completely recovered, and is now attending to his ordinary work. The paper noted eleven other cases of abscess which had been operated upon by various surgeons, and discussed the questions involved. The third case was brought forward by Dr. C. B. Ball, of Sir Patrick Dun's Hospital, and the patient was also produced. The lad had been struck with a small knife over the squamous portion of the left temporal bone ten days before admission. The wound was healed, but he had some aphasia. Pain in the head and ear supervened, and the aphasia increased. It was determined to explore. He was trephined some weeks after the original injury. A wound was found in the dura mater corresponding to the puncture of the bone. A sinus forceps was passed in, the wound opened up, and some blood clot escaped. The patient was decidedly better, but next morning he was again aphasic. The wound was washed out, and more blood clot escaped. The aphasia almost disappeared, but two days later it returned, and the wound was again washed. After this the patient progressed favorably, and is now well. Dr. Ball pointed out the *rôle* of the brain lesion, as indicated by the various symptoms of aphasia. The group of cases was a very remarkable one, and the record of them cannot fail to influence the views of the surgeons on the subject of brain surgery—*British Med. Journal*, March 3, 1888.

Gonorrhœa in a Baby.

At a meeting of the Royal Society of Physicians in Budapest, January 21, 1888, Dr. Eröss showed a case of gonorrhœa in a boy sixteen months old. The mother complained that the child had had pain in urinating for four months. The meatus of the urethra was swollen and reddened, while from the urethra itself, seven or eight drops of a greenish-yellow pus, containing gonococci, were pressed out. No similar case is found in the chapter on diseases of the sexual organs by Prof. Bókai, in Gerhardt's Manual of Diseases of Children; but Dr. Cséri has recently reported two such cases. Under suitable treatment with injections, the discharge ceased in about a week, and the child was dismissed cured in two weeks more.—*Wiener med. Presse*, February 19, 1888.

—A family named Taylor, consisting of seven persons, and living near Sidney, Ohio, have all been taken sick as the result of eating ham which contained trichinæ. The ham was eaten raw, or but partially cooked.

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CEREBRAL LOCALIZATION.

Since the brilliant developments of the experiments of Hitzig and of Ferrier in regard to what is called cerebral localization, there has been a certain tendency to the belief that the various functions of the brain are limited to definite, if not to well ascertained portions of it, and there have been men who held the opinion that in time we might be able to map out the exact part of the brain which presides over each physiological function. This fascinating hope has attracted many students of the nervous system, and has led to some remarkable and—it must be admitted—wonderfully successful surgical operations for the relief of conditions dependent upon lesions of the brain. But there is now a sort of reaction from this sanguine opinion; and a new theory is attracting attention. This theory, which is not unlike that of Flourens, who held that any function of the brain may be performed by any portion of the cortex, consists in the belief that there are two classes of so-called "centres" in the brain: absolute centres, which justify the use of such a term as cerebral localization, and relative centres or "fields," which surround them and share their functions, while, at the same time, they pass by insensible gradation into other fields, surrounding other centres, so that there are points at which it appears probable that the function of any one of several distinct centres may be exercised. This is a view which has been defended of late especially by Exner; and in recent numbers of the *Deutsche med. Wochenschrift*, JASTROWITZ describes some of the results of modern study of the brain in order to show what appears to have been demonstrated in regard to this theory. It appears that the relation of the relative fields to the absolute centres is such that it requires a much more extensive lesion of the former to produce results like those produced by a comparatively small lesion in the absolute centres. Besides this, it seems to be a fact that the more distant the point in the relative field from the absolute centre, the greater must be the lesion to produce a corresponding effect upon the function presided over by this centre. Extirpation of an absolute brain centre results in a loss of function of the relative centre. The latter cannot replace the former.

A curious result of the study of brain function is the apparent demonstration that in most animals the left hemisphere presides more especially over the motor function, and the relative fields for motor impulses are larger than in the right hemisphere; while the right hemisphere seems to preside more especially over the function of sensation and to possess larger relative fields for this function than the left hemisphere does. But absolute centres for sensation are not found distinct from the motor centres; on the contrary the most active sensory centres coincide with the motor centres, even for single members so small as the finger. The region of the facial muscles seems to be the most sharply delimited and is separated from the zones for the muscles of the body. Upon the confines of its territory, districts are found presiding over single muscle groups. The absolute tongue centre is located in both sides of the lower section of

the anterior central gyrus and at the base of the inferior frontal gyrus; a relative field for the same is found in the supramarginal gyrus, higher up on the right side than upon the left.

The problem of mapping out the location of the seat of lesion in the various forms of aphasia is of the highest interest and importance, and is one on which the near future will probably shed a brilliant light. In this connection the unique case of Paget (*Brit. Med. Jour.*, December 10, 1887), is of the most profound interest. The patient was left-handed for everything but writing, and this fact is shown to have depended upon the location of the speech-centre in the left hemisphere, instead of—as usually happens in left-handed people—in the right. Pronounced aphasia accompanied his attacks of right hemiplegia, but the faculty of speech was normal in his attacks of left hemiplegia.

'The demonstration of the existence of relative fields in connection with absolute centres in the brain, may be found to throw a new light on the formation of ideas, on the facts of re-education after lesions of the cortex, and upon many psychical functions. The ideal world of a person with partial or complete destruction of developed centres, either absolute or relative, is a different one from that of a person whose peripheral organs have been functionless from birth, or have become so from disease occurring during development. Destruction of the occipital lobes produces permanent blindness. But there is then a difference of mental life from that found in cases of congenital blindness. With destroyed centres, it is impossible to create new thought-pictures and ideas, in whose production the optical centre is a necessary factor; all connected emotions, and all movements which are their analogues or co-ordinates, all sounds and sensations which find their significance in optical images or processes, are utterly interdicted. Secondary changes, which are intimately bound up with the activities of the relative centres, must also sympathize with the deranged and extinguished functions, and the patient becomes in a certain sense demented.

THE EFFECT OF REMOVAL OF THE OVARIES.

At this time, when the ovaries of women are so frequently removed for various conditions, it becomes interesting to formulate the effect of their removal on the organism. This is especially true since it is still frequently urged, by the opponents of operative interference, that the removal of the ovaries entails very serious consequences upon the patient, such as the growth of a beard, a squeaky voice, and the loss of feminine characteristics.

Operators generally agree concerning the after history of these patients. Hegar, especially, has studied the subject. As a rule the menopause sets in at once, or after a few irregularly periodical hemorrhages. In a small percentage of cases monthly hemorrhages recur for a greater or less length of time. This is sometimes due to incomplete removal of ovarian tissue—then true menstruation continues—exceptionally to the presence of a third ovary, and usually to the presence of pelvic inflammation, vascular dilatations, blood stasis, and pelvic hyperæmia, dependent upon the pathological conditions for which the operation was done, or developing subsequently. Menstruation continues more frequently after the removal of large tumors, than after removal for other causes. This is sometimes due to incomplete removal, when a part of the ovary remains in the pedicle; sometimes to mistaken diagnosis as to the origin of the tumor, and also, more frequently, to the presence of vascular dilatations.

The uterus, tubes—when they are left—and vagina undergo the same changes, in kind, that occur after the natural menopause. The uterus sometimes undergoes very rapid and marked atrophy. The tubes are seldom left, partly because it is thought that they have an influence in the production of menstruation, and also that they are liable subsequently to become distended with fluid—hydro- or pyo-salpinx. These atropic changes are brought about by the removal of the ovaries and obliteration of neighboring vessels by ligature and thrombosis.

Many persons become stout after operation. Sexual desire usually remains, but is some-

times lost. The distinctive mental and emotional characteristics of the female are not lost. Most observers have noticed a greater frequency and intensity of the usual vasomotor disturbances, present during the natural climacteric. This is probably due to the frequent involvement of the nervous system in the morbid conditions calling for the operation, to the loss of systemic tone from previous ill-health and suffering, and also to the sudden removal of ovarian influence by extirpation.

Sterility is certain after the removal of both ovaries. Often it is present before, and a consequence of the morbid processes necessitating extirpation. The ability to have sexual intercourse is retained. The result in this respect differs from that of castration in the male, where it is usually lost. Indeed this function is frequently restored by the removal of inflamed and sensitive organs which had acted as an effectual bar. Mental depression, melancholia and suicidal tendencies, often a consequence of castration in the male, are not observed.

PROFESSIONAL CONFIDENCE.

In an editorial in the REPORTER, October 29, 1887, we expressed the opinion that it is the duty of a physician, as well as of any citizen of whatever class, to disclose to the authorities the whereabouts of a malefactor escaping from justice, although he may have learned this in his professional capacity. This opinion is sound in law, as we have assured ourselves by careful inquiry, and we believe it is equally sound from the standpoint of medical ethics, which cannot permit the shield of professional confidence to be used to protect criminals from the just reward of their crimes.

But there is a professional confidence which differs altogether from this, and which should be guarded with the greatest care. This is the confidence which a patient, unconvicted of guilt, voluntarily reposes in his or her physician. This we believe, should never be violated. No threat should be strong enough to wring from the right minded physician the secrets of his patients. Much less should a physician offer to disclose such secrets of his own free will. It is with great regret therefore that we note the fact that, according to the *Indiana Med. Journal*, March, 1888, this is exactly what a physican of Indianapolis has recently done. Being a witness in a suit for a divorce, in which the reputation of a woman was involved, he is said to have offered to reveal certain secrets which she had confided to him as her medical adviser. This offer seems to have been rejected with scorn, and the Judge who tried the case was so shocked at the conduct of the witness that he said he "would not believe on oath a physician who would reveal confidential communications received from a patient while acting in a professional capacity."

This expression of the Judge's opinion marks the sense of distrust which the conduct referred to would inspire in the mind of every decent man. Much more may physicians repudiate such conduct, and, while they may not make themselves the screens of escaping criminals, hold to the highest sense of professional honor in guarding the voluntary or involuntary confidences of their patients.

SOLVINE.

Solvine is a whitish, opalescent substance prepared by the action of sulphuric acid upon oil of almonds or castor-oil. It acquires its peculiar name because it has a remarkable solvent power upon a number of comparatively insoluble substances such as iodoform, naphthalin, naphthol, salicylic acid, cantharidin, santonin, aloin, etc. It is miscible in all proportions with glycerine, and with substances dissolved in glycerine. It forms clear mixtures with ether, chloroform, benzole, turpentine, and essential oils; and these mixtures are themselves soluble in water, if there be no great excess of any one ingredient. These facts have led to a recommendation that solvine shall be used as an excipient for a variety of medicaments intended for endermic use, instead of lard, vaseline, lanolin, and so on.

But Professor KOBERT, of Dorpat, has recently called attention to a danger which, he believes, attends the use of solvine as an external application. This danger depends

upon its ready absorption through the skin, and consists in what Kobert considers distinct toxic properties. In a paper quoted by the *Gazette Medicale*, Feb. 18, 1888, from the *Therap. Monatshefte*, Dec., 1887, Kobert states that solvine rapidly dissolves the red blood-corpuscles in a test-tube, and that when injected into the veins of warm-blooded animals, it produces serious poisoning.

These facts certainly justify the opinion expressed by Kobert that solvine should be used with prudence. Still, we believe that there are no clinical facts which warrant the theoretical fears of Kobert. How far solvine has come to be used in practice we cannot say; but there need be no timidity in employing it as a vehicle for external applications simply because its breaks up red blood-corpuscles in a test-tube, or kills frogs. Here prudence is justifiable; but not fear; and it is to be hoped that a substance which has such extraordinary powers as a solvent will not prove to be dangerous when used for the purposes for which solvine seems to be so well suited.

TRACHEOTOMY IN WHOOPING-COUGH.

After speaking, in the *Deutsche med. Wochenschrift*, Feb. 16, 1888, of the ravages of whooping-cough in Germany, which he estimates roundly at about twelve thousand deaths annually, Roser suggests the advisability of practising tracheotomy in this disease, as soon as the paroxysms of coughing have made a serious impression upon the patient's health, and when, for example, all nourishment is vomited. The justification for this suggestion lies in the fact that the coughing is very much dependent upon irritation of the larynx; and Roser believes that if the passage of air through the larynx be prevented, this irritation will cease. More than this, he thinks that if the coughing should continue after tracheotomy, it will be much less violent, since a spasmodic cough is impossible after the trachea is opened. And, finally, opening the trachea makes it comparatively easy to make local applications to the larynx, if these should be deemed advisable. In any case in which tracheotomy is performed for whooping-cough Roser recommends the use of his iodoform-tampon-canula, which we have already described in the Reporter, March 17, 1888.

The idea of adopting tracheotomy as a part of the treatment of whooping-cough will strike most American physicians as decidedly heroic; especially as the disease is by no means so dangerous here as Roser believes it to be in Germany. Still, it is not infrequently dangerous enough, and sometimes it does prove fatal; and it may be that a timely tracheotomy would save a life otherwise doomed. If so, it would be a great mistake to reject a measure which appears to have much to recommend it on purely theoretical grounds.

STATE MEDICAL SOCIETY OF ARKANSAS.

The thirteenth annual meeting of the State Medical Society of Arkansas will be held at Fort Smith, April 25–27, 1888. A "preliminary circular" announces this fact, together with the conditions of membership, and the names of the men on the various committees for the current year.

The circular, which we presume has been distributed through the State, contains the following sensible suggestions from the Secretary, Dr. L. P. Gibson:

"The members are requested to read carefully the list of committees, and to remember when their names appear there that they have not been put on the committees for ornaments, as a compliment, or to fill up the list, but solely with the object of getting as much valuable work as possible from every member of each committee.

"Chairmen are asked to correspond with every member of their respective committees, and induce them to prepare papers on the specific subjects to which they have been appointed. The foundation of the work for the meeting is almost entirely laid by the committees, and if the material furnished by them is insufficient or defective in quality, the labors of the session will be the same. The only way to have an interesting and valuable meeting is to prepare for it

beforehand, and to commence NOW. Secretaries of local Societies are requested to send to the Secretary of this Society, as soon as appointed, a list of the delegates and others who will attend from their respective counties. A full programme for the entire meeting will be sent to each member as soon as the necessary information can be obtained."

We reproduce these suggestions—not so much to call attention to the admirable method adopted to promote the success of the Arkansas State Society, as to commend it to the imitation of other State Societies. A little preliminary work of this kind could not fail to increase the activity and usefulness of any such organization.

Book Reviews.

[Any book reviewed in these columns may be obtained, upon receipt of price, from the office of the REPORTER.]

TRANSACTIONS OF THE MEDICAL ASSOCIATION OF THE STATE OF MISSOURI. Thirtieth Annual Session. 1887. 8vo, pp. xii, 159. St. Louis: Ed. E. Carreras, Printer.

One of the most interesting papers in the volume of transactions is that by Dr. H. H. Middlecamp on "The Personal Qualifications of the Surgeon," while those on the "Proper Food for Infancy and Childhood," by Dr. B. F. Hart, contains much sensible advice. A paper on "State Medicine," by Dr. J. M. Allen, and a communication by three members of the Association in regard the status and prospects of the Missouri State Board of Health are of more than local interest. As a whole, the volume is an excellent representation of the views of the medical profession in Missouri, where we find there are many firm believers in the germ-theory of disease, and some who sneer at it. The papers presented at the meeting here reported were largely devoted to surgical subjects, and not a single one discussed any of the common diseases, such as phthisis, typhoid fever, scarlet fever, etc. It is to be hoped that this indicates that these diseases are not so common in Missouri as they are in most sections of the country.

Pamphlet Notices.

ON THE MODE OF DEVELOPMENT AND COURSE OF MOLLUSCUM FIBROSUM, ETC. By R. W. TAYLOR, M.D., New York. From the *Journal of Cutaneous and Genito-Urinary Diseases*, February, 1887. 13 pp.

A FURTHER CONTRIBUTION TO THE STUDY OF MOLLUSCUM FIBROSUM; ETIOLOGY; FIBROMATOUS INFILTRATION AND ITS RELATION TO KELOID. By R. W. TAYLOR, M.D., New York. From the *Journal of Cutaneous and Genito-Urinary Diseases*, May, 1887. 11 pp.

THE TOXIC EFFECTS OF IODOFORM, CUTANEOUS AND SYSTEMIC. By R. W. TAYLOR, M.D., New York. From the *New York Medical Journal*, October 1, 1887. 20 pp.

A SECOND CLINICAL STUDY OF HEMIANOPSIA. CASES OF CHIASM-LESION. DEMONSTRATION OF HEMIOPIC PUPILLARY INACTION. By E. C. SEGUIN, M.D., New York. From the *Journal of Nervous and Mental Disease*, November-December, 1887. 19 pp.

A CLINICAL LECTURE ON TUBERCULAR MENINGITIS. By DANIEL R. BROWER, M.D., Chicago, Ill. From the *Journal of the American Medical Association*, January 7, 1888. 15 pp.

TUBERCLE OF THE TESTIS. By R. W. TAYLOR, M.D., New York. From the *American Journal of the Medical Sciences*, January, 1888. 8 pp.

PUNCTURE OF THE INTESTINE FOR TYMPANITES. By J. CHRIS. LANGE, M.D., Pittsburgh, Pa. From the *Pittsburgh Medical Review*, February, 1888. 12 pp.

ON THE USE OF THE VAGINAL TAMPON IN THE TREATMENT OF CERTAIN EFFECTS FOLLOWING PELVIC INFLAMMATIONS. By THOMAS ADDIS EMMET, M.D., New York. From the *New York Medical Journal*, February 18, 1888. 16 pp.

—Dr. Taylor's pamphlet contains an interesting study of the pathological history of molluscum fibrosum, especially in connection with its relation to acrochordon and other warty growths on the skin. The relation described is very interesting, and rests upon a careful study of a case of molluscum fibrosum, which covered a long period of years.

—Dr. Taylor's second paper on molluscum fibrosum contains a continuation of the study which formed the object of the pamphlet last noticed. The author here considers more especially the relation of molluscum fibrosum to keloid, and describes two cases under his own observation in which the appearance of the former seems to be attributable to traumatism, thus corresponding to the usual history of keloid.

—Dr. Taylor has studied the local and systemic effects of iodoform used as an antiseptic, and he presents the results of this study in a very practical paper. He finds that there are too many reports of mild or severe iodoform poisoning to permit an explanation of them on the ground of idiosyncrasy. He advises surgeons not to use iodoform unsparingly, not to rub it into fresh wounds, not to renew it too often, not to combine its use with the employment of other antiseptics, and to use it with caution on patients who are quite young or quite old, or who are anemic, neurotic, or suffering with a weak heart or with Bright's disease.

—Dr. Seguin's paper is a very finished study of the interesting subject of hemianopsia, as illustrated by three cases, the clinical history and rational signs of which seem to justify his opinion that the defect was due to a lesion situated at the optic chiasm. The cases are admirably described, and the written description is supplemented by excellent wood-cuts. The method of investigating these curious cases, as given by Dr. Seguin, is calculated to be of especial service to students of diseases of the eye and of nervous diseases.

—Dr. Brower's paper describes the history and pathological lesions of tubercular meningitis very clearly, and especially well the changes which are sometimes observed at the inner margin of the iris. The last are illustrated with three diagramatic

wood-cuts. Dr. Brower expresses the opinion that inunctions of iodoform upon the shaved scalp are the best means of treatment yet discovered, and prudently suggests that careful management of children with a tendency to tubercle may go far toward preventing the development of this dangerous disease.

—Dr. Taylor gives the clinical history and the macroscopical and microscopical appearances found in two cases in which he removed both testes for supposed tuberculosis. In both the diagnosis seems to have been correct, although no mention is made of finding tubercle bacilli in the organs removed from one of the patients, while such a discovery is distinctly asserted of the other. The paper is illustrated with well executed wood-cuts.

—Dr. Lange takes the somewhat unusual position that puncture of the intestine for the liberation of gas, which is producing great distension of the abdomen and consequent pressure upon the contents of the thorax, is a justifiable and useful operation. Most surgeons have a great fear that such a procedure may cause peritonitis, and that its dangers overbalance its benefits. Dr. Lange holds a diametrically opposite opinion, and supports this opinion by an interesting argument, and by citing eight cases in which he punctured the intestine for tympanites with excellent results. Two of his patients died, it is true; but there seems no reason to attribute their death to the operation, while six of his patients recovered. For the details of these cases and the manner of performing the operation we must refer our readers to Dr. Lange's valuable paper.

—The first part of Dr. Emmet's scholarly paper is occupied with a statement of the advantages to be derived, in suitable cases, from the use of hot-water injections for the relief of inflammation of the pelvic viscera of women. He then considers the use of the vaginal tampon, which does great good in certain cases of inflammation with relaxation of the veins of the uterus and its appendages. The material preferred by Dr. Emmet is clean cotton—not absorbent cotton. He choses this rather than wool, which is now in great favor, and which appears in the hands of other surgeons to have answered the purpose admirably.

Literary Notes and Queries.

[In this column the Reporter will publish short items of literary interest and questions addressed to this Journal or its readers, and answers to them, in regard to any literary matters: books, authors, places and prices of publications, etc.]

—*The Climatologist* is the name of a new periodical "conducted" by William C. Chase, and published in Washington, D. C. It is a quarterly journal, large octavo size; price, 50 cents a year. The first number contains 64 pages. The matter is interesting, though much of it is far from fresh. The paper and printing are poor, and there are a number of evidences of careless proof-reading. It is to be regretted, also, that its first number is disfigured by advertisements inserted in the middle of the reading pages, and inseparable from a part of its scientific contents. A journal which appeals to the sympathy of older ones should not begin with a practice which is regretted by all, and repudiated by the best.

—The *Dental Cosmos* for March, 1888, contains 80 octavo pages. This increase in the size of the *Cosmos* will be permanent, and will materially enhance the value of a periodical which always enjoys an enviable reputation.

The Prophylactic is the name under which the *Canada Health Journal* now appears. The first number of the new series is dated February, 1888. It contains 40 octavo pages of interesting matter relating to hygiene. It is published in New York by M. B. Playter & Co., monthly, at $1.75 a year.

—"Dr. Griffith Gramtry," by Julian Hawthorne, in *The Cosmopolitan* for March, is a dramatic story, hinging upon the hypnotic power that an unscrupulous man exerted upon a couple, just married, and spending the honeymoon on a picturesque portion of the Irish coast.

Correspondence.

To what Class of Fungi does the Diphtheritic Belong?

Editor Med. and Surg. Reporter:

Sir:—In looking up the literature of fungi, my attention was called to some quotations from the works of Prof. Hurtig (*Nature*, January 12 and 19, 1888), on the *dry-rot* of timber, which he shows proceeds from the growth of the *merulius lacrymans*, and from the *polyporus vapriosus*. The surface of the fallen timber or joist is covered with a whiteish or colored membrane made up of a mat of fine threads, the roots or *hyphe*, penetrating the pores of the wood deeply, disintegrating it and causing it to fall to pieces. When the nutriment or moisture under it is exhausted, it sends out long threads to other wood where moisture is more abundant.

The *merulius* grows on dead timber; the *polyporus* on living, its mycelium appearing in long, white ribbons, or thick, leathery membranes of a yellow color. Its roots extend deeply into the tissue of the wood, causing softening and decay. It can be transplanted, but for some time the spores could not be made to germinate. It was found that the *merulius* required an alkali, which, in damp places, is in the form of ammonia, from decomposition. It is not stated how the *polyporus* is produced from spores. In making some microscopic examinations of both forms of fungi, I was struck with the resemblance of the mycelium of the *polyporus vapriosus* to the diphtheritic membrane, and also to the similarity of its transference and manner of reproduction. Diphtheritic membrane can be transplanted. I have a distinct recollection of a patch that appeared on a small bruise on my finger, and the difficulty I

had in removing it from a large, blistered surface. We have been classifying it as a *schizomycetis*, when in fact, it is a fungus of a higher order: a *hyphomycetis*. We have been looking for the bacteria and micrococci, which produced the disease, and describing the membrane as an exudation, instead of treating it as a fungus that grows on the surface and has its roots penetrating the tissues. We have two or three diseases evidently of the same class, but milder: the aphthæ or thrush of children, which is recognized as a mould—*oidium albicans*—whose roots penetrate the mucus membrane, and which is capable of being transplanted and being propagated by spores. We have also favus and herpes (ringworm?) which are fungus diseases.

There is no diphtheria now in my vicinity, so that at present I have no means of making any microscopic examination. Will some one who has the opportunity, do so? For, if the fact can be established, it will have much to do with our treatment of this formidable disease. A fungus is planted in the throat; it spreads by fibrillations; its roots enter into the tissues below, disintegrating them and generating a poison, which is taken up by the circulation; and then a local disease becomes constitutional. The softened tissue forms a soil for the development of bacteria and putrefaction, and entire destruction takes place. Otherwise, the membrane extends farther into the air-passages, and so fills them up that death takes place from suffocation. Diphtheria transplanted to the surface produces severe irritation and a troublesome sore, which is not cured until the membrane is destroyed.

P. J. Farnsworth, M. D.

Clinton, Iowa, Feb. 22, 1888.

Pamphlets Noticed.

Editor Medical and Surg. Reporter:

Sir:—The Reporter often contains notices of pamphlets which seem to be very valuable. Of whom may they be procured? Of the general medical book trade?

Yours truly,

Drs. Worthington & Wilson.

Merrill, Wis., March 6, 1888.

[One who wishes to obtain a pamphlet noticed in the Reporter may address us for it, or the author of the pamphlet, or the journal in which it originally appeared. Either course will usually secure a copy without cost, except postage, which ought always to be sent.—Editor.]

Notes and Comments.

Bichloride of Mercury Internally in Circum-uterine Inflammations.

In the *New York Med. Journal*, January 28, 1888, Dr. H. N. Vineberg has a communication upon the internal administration of bichloride of mercury as an adjunct to the local treatment of circum-uterine inflammations. He reports several cases in which he has employed this drug, which he gives with compound tincture of gentian and water, in the strength of one grain to three ounces of the mixture; dose, a teaspoonful three times a day, after meals.

The patients, he says, took the mixture readily, and, with only one or two exceptions, no complaint was made on the score of its taste. Some of the patients took the remedy in the dose stated continuously for four or five weeks without the slightest evidence of mercurialism. It was usually then omitted for a week, more for precaution's sake than on account of any untoward effect of the drug. On the contrary, the appetite of the patients while they were taking it usually improved, as did also their digestive functions. When anæmia was present, the bichloride was combined either with tincture of chloride of iron or with reduced iron in the form of a pill. In some cases he gave as much as one-sixteenth of a grain—a dose which the patients seemed to bear as well as the smaller ones. From his observations, which have just been referred to, he draws the following conclusions, which he thinks are warranted:

1. The use of bichloride of mercury internally forms a valuable aid to the local treatment of circum-uterine inflammations.

2. In the doses necessary for its resolvent effect the drug may be given for several weeks without any untoward constitutional manifestations.

3. In some cases, where the inflammatory products are deeply situated within the pelvis, the internal use of the drug seems to be more efficacious than the most approved local treatment.

4. A short course of the drug often serves as an important means for the differential diagnosis of the various obscure conditions which give rise to pelvic pain.

Communication of Tuberculosis by Ritual Circumcision.

Mr. F. S. Eve, assistant surgeon to the London Hospital, in a communication on the above subject to the *Lancet*, January 28, 1888, reports the case of a Jewish child,

five months old, who was admitted into the hospital on August 23, 1887, with a large globular, fluctuating swelling in each groin. The skin over these swellings was red and thinned. On the under surface of the penis, at the site of the frænum, was a small superficial sore. The abscesses were opened, and a quantity of pus, containing some masses of caseous material, was evacuated. Their walls were then scraped. The child's condition improved, and in fourteen days he left the hospital, with a sinus in each groin, discharging only a small amount of pus.

The mother of the child stated that it had been circumcised on the eighth day, and the wound appeared to heal properly. Six weeks afterwards she noticed a small swelling in each groin, and it was then found that the circumcision wound had either broken out again or had not healed. Caseous material taken from the abscesses by Mr. Eve produced intense general tuberculosis in a Guinea-pig which was inoculated with it.

Oil of Sandal Wood for Gonorrhœa.

Dr. M. H. Linhart, in *Wiener med. Presse*, Nos. 29–34, 1887, strongly recommends the use of oleum santali in the treatment of gonorrhœa. He gives the oil in capsules containing each three drops; and orders these capsules to be taken each morning and evening—that is, eighteen drops each day. When the discharge does not diminish materially in ten days, he increases the quantity to be taken to twenty-four, and, in rare cases, to thirty drops a day.

According to Linhart, sandal-wood oil can be given in any stage of gonorrhœa, and is not contra-indicated by any of its complications. In his experience the average time required for a cure under this treatment was four weeks; by the method of injections he has found it to be six weeks.

The use of sandal-wood oil for gonorrhœa is not a therapeutic novelty, and it is certainly not an infallible means of effecting a cure; but it is a good thing to know what it may do, and to give it a trial in the treatment of this stubborn disorder.

Application for Warts.

E. Vidal recommends the following solution:

℞ Acidi salicylici.....1 part
Alcoholis (90 %).....1 "
Etheris sulph.....2½ "
Collodii.....5 "
M. Sig.—Paint the warts daily with the solution.

Oleate of Copper for Ringworm.

The *New Orleans Med. and Surg. Journal*, March, 1888, states that Dr. Blanc, of that city, has recently treated twenty-seven cases of ringworm of the scalp with oleate of copper. The following is the formula:

Oleate of copper.....½ drachm.
Vaseline (or lanoline).....1 ounce.
Mix.

The child's head was first washed thoroughly with soft soap and warm water, after the hair had been cut as close as possible. The head is then well dried, and the ointment rubbed in the scalp, over and beyond the diseased spots, and allowed to remain on. The head is scrubbed only once a day, but the ointment is applied night and morning. Chrysarobin was also tried, but abandoned. Dr. Blanc found the oleate of copper especially useful in cases of tinea complicated with "kerion" (a humid, boggy, honeycombed condition).

The average duration of treatment was four months and four days—the shortest time being seventy-four days, and the longest one hundred and sixty-six days. All the cases were cured. The disease was communicated to the boys by two pet cats who were affected with it. Epilation was not practiced in any of the cases.

This result is an exceedingly happy one, and Dr. Blanc deserves to be congratulated upon it. It is to be regretted, however, that no mention is made of the length of time the boys were kept under observation after their apparent complete recovery. The disease is so treacherous that no case should be finally dismissed as positively cured which has not been found to be free from all evidence of relapse for at least two months.

For Rheumatism.

L. A. Smith sends to the *Chemist and Druggist*, Nov. 26, 1887, a sample of a specific for rheumatism, to which many marvellous cures are attributed,—some, indeed, with one application. The "specific" is an oily fluid, of a pale straw color and slightly terebinthinate odor. A preparation similar to it is afforded by the following formula:

Oil of anise.....f℥ij
Oil of turpentine.....f℥iij
Oil of camphor (natural).....f℥ij
Olive oil to.....f℥x
Mix in the order given.

The statements regarding the miraculous influences of such preparations as this must always be taken *cum grano salis*. The heating nature of the mixture no doubt affords temporary relief, which is enhanced by faith,—and there is a great deal in the rubbing.

Professional Confidence.

The following somewhat unusual action of a medical man in reference to secrets of the medical "confessional" is narrated in the *India Medical Gazette*. In the court of Madras, A prosecuted B under the Penal Code, for adultery with A's wife. The fact was sworn to by A's wife in court. Dr. C., a surgeon in the Madras medical service, sent word to the counsel for the defense that he could give testimony which would help the accused. On being summoned, he narrated facts made known to him in conversation with Mrs. A., regarding a previous adultery. This evidence was ruled out, as Mrs. A. was present to declare what she did say, and she totally repudiated the conversation. The judge, moreover, censured the doctor for volunteering to give away the secrets reposed in him professionally, but said that if he were summoned involuntarily he would have been obliged to testify to facts thus learned. If the latter is the case, and the law had no respect for professional secrecy when it summons a witness to its own aid, it is a delicate question how far, supposing the doctor to have been honest in his testimony, he was obliged to sit still and see an innocent man suffer injustice from want of that evidence which under slightly different circumstances the law has a right to extort.—*Boston Med. and Surg. Journal*, March 8, 1888.

Rumination in the Human Subject.

Two cases of this rare abnormality are recorded by Dr. Axel Johannessen in the *Zeitschrift für klin. Med.* 1887, Bd. 12, S. 321. In the first case, the patient, a man 25 years old, had suffered in his fifteenth or sixteenth year, from some cerebral affection, diplopia, giddiness, tinnitus aurium, head ache, and stomach ache being present. After these, came disturbances of some organs of sense, convergent squint of the right eye, deafness of both sides. Later on, deposits of chalk were observed in the tympanum, and loss of smell on the left side. Moreover, all kinds of food after they had been chewed and swallowed, returned in from half an hour to two hours, and were again masticated and swallowed, with pleasure. The regurgitated morsels were not ejected until within the last six months, since which time a sour, bad smelling fluid has accompanied them. Since then, also the appetite has failed, and the patient has become thinner. In the second case, the rumination appears to have come on after the eruption of some teeth, which was accompanied with febrile symptoms. The patient was a healthy boy, 10 years of age, born of healthy parents. The boy is now a man of 28, but the rumination still continues. It can neither be set up, nor kept back by any voluntary effort, and in this case also it is associated with pleasurable sensations. Before the regurgitation begins he experiences a feeling of pressure about the level of the larynx. This, however, disappears when the regurgitation has taken place.—*Medical Press and Circular*, Feb. 1, 1888.

Large Nævus in an Unusual Location.

Dr. A. McShane records the following interesting case in the *New Orleans Medical and Surgical Journal*, December, 1887: The patient was a young white man, aged 20, in good physical condition. Five years ago a friend, while looking at his back teeth, observed a large swelling on the right side of the soft palate. In October, 1887, there was a large purplish bulging in that locality, involving the pillars of the fauces and the uvula, which is three-fourths of an inch long, and very thick. Immediately to the right of the uvula is a slightly elongated, blackish mass, projecting downward, which consists of distended veins. All over the surface of the swelling numerous dilated blood-vessels are seen, giving a mottled, purplish aspect to the tumor. The swelling is soft. The patient does not know how long he has had it; he himself first noticed it five years ago, and it was as large then as it is now. The swelling is a large nævus, occurring on the mucous membrane of the soft palate and fauces. It causes no inconvenience in swallowing or speaking, but swells a little when he gets a cold.

The Propriety of Operating for Fistula in Ano when Phthisis Exists.

Dr. Joseph M. Mathews, Professor of Surgery in the Kentucky School of Medicine, states his opinions with reference to the propriety of operating for fistula in ano when phthisis exists, in the following propositions, (*Atlanta Med. and Surg. Journal*, February, 1888):

1. In incipient phthisis the operation is always justifiable, other things being equal.

2. In the rapid, progressive fistula, an operation should be done to save tissue and prevent serious consequences.

3. If great cough exists it should militate against the operation.

4. If it can be determined that the sinus is single and the discharge, inconvenience and pain not great, advise against the operation.

So-called Idiopathic Dilatation of the Colon.

At a meeting of the Clinical Society, of London, Jan. 27, 1888, Dr. Angel Money and Mr. S. Paget read a paper on a case of so-called idiopathic dilatation of the colon. The patient was a man 55 years old, an habitual drunkard who suffered from enormous distention of the colon, with dispnœa and bronchitis. The girth of the abdomen was over 60 inches, and the measure from the ensiform cartilage to the pubes 26 inches. There was albuminuria. He was first treated by Mr. Paget at St. Thomas's Home by repeated punctures. These gave great relief; he improved so much that he refused further treatment, and returned to his drunken habits. He was admitted into University College Hospital a week later, under Dr. Angel Money, with the same enormous distention, lividity, and dyspnœa. He was much relieved by the use of the long rectal tube, but sank and died a week after admission. At the necropsy all the signs of habitual drunkenness were found, including typical "hobnail" liver. There was enormous distention of the colon, principally of the sigmoid flexure, which formed two huge sacs extending right across the abdominal cavity. There was no organic stricture. Dr. Money is of opinion that a twist of the sigmoid flexure or a spasmodic stricture may have been present; or else that some morbid state of the blood, or the mere presence of an excess of gas, may have started the disease. The bowel was hypertrophied as well as dilated.

The omentum was in a state of chronic cirrhosis, but was not adherent, nor displaced into a hernia. The meso-colon was not unnaturally long.—*Medical Press and Circular*, Feb. 1, 1888.

Court-Bibles and Disease Germs.

Dr. Drescher, State Analyst of New Jersey, was a witness in a case, tried before a Justice of Newark, N. J., on March 2, and before giving testimony in the case, he merely made a pretence of touching his lips to the time-stained volume. The counsel for the accused observed the doctor's omission, and, after arguing the case in every way that his ingenuity could suggest, he raised the point that Dr. Drescher's oath in the case was invalid, because he intentionally avoided kissing the book.

A tilt between the lawyers followed, and Dr. Drescher admitted that he did not kiss the book, but said the omission was prompted by sanitary motives and not by irreverence. He said he was afraid to touch his lips to an article that might cause disease. "So many different persons have kissed that book that I do not think it safe to touch my lips to it."

Justice Otto said the case must be reopened, and that the doctor must be sworn properly. Dr. Drescher then took the Bible, gave it a sounding smack, and then vigorously rubbed his lips with his handkerchief to remove any bacterial germs which might have been taken up in the process of osculation.

The Language of Twins.

Dr. W. H. S. Crabb writes to the *St. Louis Med. and Surg. Journal*, Jan., 1888, that he has frequently observed that twin children, if both live and are kept together, do not learn to speak and use words that can be understood as readily as other children, but on the contrary they almost always understand each other. He is satisfied that there is really something more than a mere coincidence in it. He says he is acquainted with a couple of twin boys, seven years old, who can understand each other, although it is impossible for their parents or any other person to understand one word they say. He also knows of twin girls, sixteen years old, who can talk to each other, but to another person their language would convey as little meaning as the ancient Hebrew would to a person who had never learned that language. The young ladies mentioned can use a great many words common to the English language in talking with other people, but in conversation with each other they use a language of their own invention and peculiar to themselves. In each of the cases referred to he recommended the separation of the children so that necessity, the mother of invention, would cause them to use the language of the persons with whom they come in contact.

Prescriptions for Phthisis.

The Paris correspondent of the *Medical Press and Circular*, February 1, 1888, states that the following prescriptions have been much used by Paris physicians:

℞ Potass. iodidi.....ʒiss
Sodii arseniat.....gr. j
Syrupi aurantii.....fʒij
Aquæ .....q. s. ad fʒx
M. S.—Tablespoonful every morning.

℞ Creasoti.....mj
Iodoformi.....gr. ss
Ext. opii.....gr. ½
M. ft. pil. No. j. S.—To be taken morning, noon and night.

Christian Science.

Dr. Edward J. Doering writes to the *Chicago Tribune*, January 17, 1888, that the recent death in Chicago of a patient of the so-called Christian scientists was by no means the first occurrence of this kind. He states that he, as well as many other physicians, has signed death certificates for many deluded victims of "Christian Science." He adds: "We do so in order to save the family and friends of the deceased the mortification of a Coroner's inquest, when we are satisfied, of course, that nothing of a criminal nature—in a legal sense—has occurred. If these Christian healers could only be sentenced to the work-house at hard labor for the term of one year, and their patients be sent for a similar period of time to an institute for feeble-minded persons, a large number of cranks could be restored to common sense and many an untimely death be averted.

Tetanus after Hypodermic Injection.

The *Lancet*, January 28, 1888, states that a child six years old suffering from miliary fever was treated first with quinine administered in pilules and by inunction, and then by a subcutaneous injection. One month later the fever had disappeared, but the child complained of pains in the left arm and at the point of injection; trismus supervened in three days, tetanus developed, and death occurred on the sixth day. If this was really a case of traumatic tetanus, the period of incubation was rather longer than the usual seven to fourteen days.

Adonis Vernalis.

This drug was first recommended by Meud and Cullen, in England, as a diuretic and purgative, and subsequently by G. Sée, Laborde and Le Gris. It is used in place of digitalis in heart diseases and dropsy, but its action is greater as a diuretic than as a heart stimulant. Nausea, vomiting and diarrhœa are easily produced by it, but it has no cumulative action. It may be given in the form of the infusion, of a strength of two to four per cent., in doses of a tablespoonful every two or three hours.

Congenital Torticollis.

Dr. John D. S. Davis, from a study of this affection (*N. Y. Med. Journal*, February 4, 1888), concludes:

1. That it is rare and doubtful if ever congenital torticollis is produced through the act of delivery, resulting from faulty application of the forceps, or from pulling out the trunk before the head is extracted; but that the cause may often be found in the low vitality of the fœtus of scrofulous parentage.

2. The complete resection of all the contracted (contractured) tissues is necessary before attempting to restore the head to its normal position.

3. That, after complete section of the tissues, the head should be placed immediately in the normal position, and retained there for ten or fifteen days.

Improved Method of Making Suppositories.

Some time ago Mr. Adolph Vomacka, the accomplished pharmacist and editor of the *Rundschau* (Prag), contributed to his journal a new and improved method of making suppositories of those medicines which do not easily or thoroughly incorporate with cacao butter under the old process (such, for instance, as green extracts, iodoform, etc.). Very recently M. Leboutte, a Belgian pharmacist, contributed the same, as original, to the *Bulletin* of the Pharmaceutical Society of Brussels. It is as follows: Reduce a sufficiency of cacao butter to a powder in a mortar, mix the medicinal agent, and add a small quantity of soap. When the whole is reduced to a powder, add a small quantity of water and work up the mass as though pills were to be made. Divide and make into cones in the usual manner.—*National Druggist*, Feb. 15, 1888.

Terpinol Pills.

Terpinol, the new antiseptic derivative of turpentine, is coming rapidly into practice not only in Europe but in America. Benzoate of ammonium is one of the remedies with which it is combined in prescriptions, especially in pill form. Considerable difficulty was at first experienced in making the latter, and the following, sent by O. Kaspar to the *Chemist and Druggist*, is the best solution of the difficulty we have yet seen:

Take of

Terpinol	10 parts.
Ammonium benzoate	10 parts.
Ceræ flav. ros.	10 parts.
Pulvis constituens.	10 parts.
Glycerin, tragacanth	q. s.

The *pulvis constituens*, constituting the fourth ingredient, consists of equal parts of gum arabic, sugar and powdered althea. The only difficulty about this formula is that it makes rather a large pill.—*National Druggist*, Feb. 15, 1888.

Detection of Concealed Insanity.

Dr. Allan McLane Hamilton, in a communication to the *New York Med. Journal*, upon the detection of concealed insanity by the use of nitrous oxide gas, says that its use for that purpose was suggested accidentally to him by a case of insanity with concealed delusions. He has invariably found, when the patients studiously avoided betraying their mental weakness from fear of asylum detention or commitment, or when there was no such restraint—that the simple suggestion of the suspected condition, or the mere establishment of the first grade of intoxication—would result in their giving prompt expression to not only delusions, but sometimes hallucinations. The particular form of monomania would be intensified, and even new applications of the dominant false idea would be made.

Physiological and toxic Action of Cocaine.

Le Concours Médical states that M. Laffont has communicated to the Academy of Sciences and the Academy of Medicine some conclusions relative to the following physiological effects produced by cocaine:

1. General peripheral analgesia, only involving the extremities of the peripheral nerves.

2. Preservation of the excitability of the nervous trunk, and even a notable increase in this excitability.

3. Persistence of the reflexes in spite of peripheral analgesia.

4. Finally, and as a deduction from these facts, the contrast between the action of cocaine and that of curare; the former exerting its influence upon the sensitive nerves; the later upon the motor nerves.

M. Laborde confirmed the investigations of Laffont, and suggested that there was a true physiological antagonism between cocaine and curare.

Extraction of the First or Sixth Year Molar.

In a paper in the *Independent Practitioner*, February, 1888, on the extraction of the first or sixth year molars, Dr. G. W. Weld makes the following points with reference to it:

1. Its title to longevity can only be questioned under neglect and abuse. 2. It is the keystone molar; with it the integrity of the arch is preserved; without it the usefulness of the arch is impaired, if not destroyed. 3. Its extraction at an early period signifies a loss of masticating surface that is absolutely detrimental to the health and comfort of the patient in early life. 4. In view of the prominent position it occupies in the arch and its relation and influence as a just poise or balance in the distribution of the varied strains incident to mastication, its extraction can only be considered a physiological mistake.

Physostigmin in Chorea.

L. Riess reports, in the *Berliner klin. Wochenschrift*, No. 22, 1887, the result of his treatment of chorea and other hyperkinetic affections with physostigmin. He has obtained successful results from hypodermic injections of $\frac{1}{60} - \frac{1}{20}$ of a grain several times a day. The duration of the disease was shortened in nearly all cases, and recovery sometimes occurred in five days. With the exception of vomiting, no bad effects of the drug were observed.

Cocaine as a Means of Differential Diagnosis.

In a communication to the *Wiener med. Wochenschrift*, No. 44, 1887, Baumgarten expresses the opinion that if an infiltration in the larynx subsides for some time after being painted with cocaine, the diagnosis can be made of a catarrhal trouble. But if the cocaine produces no diminution in the swelling, nor paleness, then the disease is to be regarded as serious; and if no diminution in swelling, nor pallor, occur even after some days, then catarrhal troubles can be excluded.

Early Appearance of Menopause.

Dr. I. K. Frazer communicates to the Texas *Courier of Medicine*, February, 1888, the notes of a case in which the menopause was apparently established at the early age of nineteen years. He is unable to assign a cause for this result, as the general health seems perfect.

Lunacy in Scotland.

The twenty-ninth annual report of the Lunacy Board for Scotland deals with the statistics of lunacy from 1858 to 1887, from which it appears that the number of pauper lunatics in asylums had increased up to 1882, when it stood at 188 per 100,000. Last year the number fell to 184. The number of private lunatics in establishments reached 39 per 100,000 in 1881, and now stands at 38. There had been a steady annual increase up to 1882.

Toothache.

Dr. Popoff, writing in the *Russkaya Meditzina*, states that he has succeeded in relieving toothache caused by caries of the teeth by making the patient rinse the mouth every half-hour with a dessertspoonful of a twenty per cent. solution of permanganate of potash, taking care to hold the liquid in the mouth for some minutes.

Simple Prescription for Small-Pox.

The *Chemist and Druggist* says that Sheffield chemists have of late had quite a run on the following prescription:

Cream of tartar	1 oz
Powdered rhubarb	14 grains

It seems that a clergyman, in a letter written to a Leeds newspaper, had recommended it as an infallible remedy for, and preventive of, small-pox. The Sheffield papers copied his letter, and rhubarb and cream of tartar now hold the field.

Pruritus Vulvæ following Leucorrhœa.

Verrier recommends the following solution:

Carbolic acid	9 minims
Acetate of morphine	7 grains
Dilute hydrocyanic acid	50 minims
Glycerine	3 drachms
Water	4½ ounces

After the parts have been washed and allowed to dry, they should be dusted with powdered starch. If the pruritus still persists, insert a cotton tampon, wet with the above solution, between the lips of the vulva, and secure it with a bandage.—*Union Médicale du Canada*, February, 1888.

Formula for Dysmenorrhœa.

L'Union Médicale du Canada says that Calvin's formula is:

Tincture of gelsemium,	
Camphor water,	
Deodorized tincture of opium	āā..f℥ij

Mix. Dose, 30 drops every two hours.

Asymmetry of the Face.

Hasse has made an interesting observation upon asymmetry of the face. He had found that the famous statue of the Venus of Milo is executed with anatomical accuracy in all essential particulars; but Henke, on the contrary, found fault, among other things, with the obliquity of the face of the Venus. Hasse has subsequently made the surprising statement that not only the Venus of Milo, but all of us have oblique faces. This asymmetry is confined to the upper half of the face, the mouth and chin being completely symmetrical. As a rule, the left half of the skull predominates, in consequence of the stronger development of the left half of the brain, and the nose, as we all know, deviates to the right or left. Moreover, the region of the right eye is generally higher than that of the left, while the left eye is nearer the median line. The left ear, as a rule, is higher than the right. These opinions are supported by reproductions of photographs of the Venus and of living men and women.—*Deutsche med. Wochenschrift.* February 16, 1888.

The Last of another Anæsthetic Alkaloid.

There appears great reason to conclude that "drumine," an alleged anæsthetic alkaloid derived from the *euphorbia Drumondii*, is not only not an anæsthetic, but is not even an alkaloid. It seems to be a compound made up in great part of calcium oxalate. Such at least is the conclusion pointed to by the investigations of several contributors to a recent issue of the *Pharmaceutical Journal and Transactions*. Moreover, it is announced that the purveyors of "drumine," having found it unsatisfactory, no longer furnish it. It will be remembered that "drumine" was brought into notice by Dr. John Reid, of Melbourne. Its career is not unlike that of "gleditschine." Some of our European contemporaries have seen fit to speak of the "gleditschine" affair as "an American swindle." The *Bulletin général de thérapeutique*, commenting on the matter of "drumine," more politely refers to it as "*une mystification*," without any adjective denoting its Australian origin.—*N. Y. Med. Journal*, Feb. 11, 1888.

Compulsory Vaccination.

The following extract from *The Sanitarian* would seem to indicate that a compulsory vaccination law has its advantages: "The success of the anti-vaccinationists is aptly shown by the results in Zurich, Switzerland, where for a number of years, until 1883, a compulsory vaccination law obtained, and small-pox was wholly prevented (not a single case occurred in 1882). This result was seized upon in the following year by the anti-vaccinationists, and used against the necessity for any such law, and it seems they had sufficient influence to cause its repeal. The death returns for that year (1883) showed that for every thousand deaths two were caused by small-pox; in 1884, there were three; in 1885, seventeen; and in the first quarter of 1886, eighty-five."

Reception to Prof. Agnew.

A reception by the Alumni of the Medical Department of the University of Pennsylvania and the three undergraduate classes will be given to Prof. Agnew, on Tuesday, April 24, 1888, in honor of the fiftieth anniversary of his graduation. Those desiring to participate should communicate with Dr. Tyson, at the University.

Prof. Unna's Practical Course in Dermatology.

American medical men who are to be in Europe this year may be interested to learn that Prof. P. G. Unna, of Hamburg, intends to give a six months course on practical dermatology, beginning early in April, in which he expects to cover the whole ground of the histology, bacteriology, diagnosis and therapeutics of skin-diseases.

In a circular announcing this fact, Dr. Unna states that he hopes that his instructions, backed by the use of his abundant clinical material, will add to this specialty efficient young forces.

Medical Society of the State of Pennsylvania.

The Thirty-ninth Annual Meeting will be held in Philadelphia, on Tuesday, Wednesday, Thursday and Friday, June 5, 6, 7 and 8, 1888, commencing on Tuesday, June 5, at 9 A. M.

Appointments for 1888.—Address on Practice of Medicine: Dr. E. R. Mayer, of Wilkesbarre; address on Surgery: Dr. Jas. McCann, of Pittsburg; address on Obstetrics: Dr. Theophilus Parvin, of Philadelphia: address on Mental Disorders: Dr. Horatio C. Wood, of Philadelphia; address on Otology: Dr. B. A. Randall, of Philadelphia; address on Hygiene: Dr. Traill Green, of Easton.

Resolutions to be acted upon.—1. Offered by Dr. S. Solis Cohen, of Philadelphia:—"There shall annually be constituted, as the first item of business at the afternoon session of the first day, a Nominating Committee, to consist of one member named by the majority vote of the delegation of each county, who shall report, as the first item of business in the afternoon session of the second day, a list of candidates for officers and necessary committees. In the Nominating Committee each member shall cast a number of votes equal to the number of delegates from the county in actual attendance upon the session."

2. Offered by Dr. A. Enfield, of Bedford:—"The time and place of meeting shall be determined by the Nominating Committee, and the sessions shall always begin at 9 A. M., and continue for four days; and the Committee of Arrangements shall adjust papers, etc., in accordance with this by-law."

3. Offered by Dr. A. M. Pollock, of Pittsburg:—"That the Censors of the appropriate district shall have power to determine whether a resident of one county shall be entitled to become a member of an adjacent county society which may be more convenient for him to attend."

Applications to read papers at this session should be sent *not later than April 15*, to Dr. John H. Packard, Chairman of Committee of Arrangements, 1926 Spruce street, Philadelphia.

Secretaries of County Medical Societies are earnestly requested to forward at once complete lists of their officers and members, giving the post-office address of each.

Every delegate, before admission, must present a certificate of delegation, signed by the President or Secretary of his County Society. Every permanent member (not a delegate), before admission, shall present a certificate of good standing in his County Society.—(*Extract from the Constitution.*)

Railroad facilities will be announced when obtained. All who desire excursion orders should notify the permanent Secretary, Dr. William B. Atkinson, Philadelphia, stating which railroad must be used.

Association of American Medical Editors.

The next meeting of the Association of American Medical Editors will be held in Cincinnati, Monday evening, May 7. After the address of the President, Dr. William Porter, of St. Louis, the Association will consider a plan of organization reported by a committee of which Dr. McMurtry, of Danville, Ky., is chairman. Officers for the ensuing year will be elected, and the Association will then discuss the following questions:

1. Is the multiplicity of medical journals an advantage to the profession? To be discussed by Drs. Crothers, Hartford; Sim, Memphis; Wile, Conn.; Love, St. Louis; Culbertson, Cincinnati; Cushing, Boston; Coomes, Louisville, and Gray, Chicago.

2. How far do medical journals distributed by drug houses and manufacturers interfere with regular medical journalism? To be discussed by Drs. Reynolds, Louisville; Davis, Chicago; Shoemaker, Philadelphia; Bond, St. Louis; Connor, Detroit; Kiernan, Chicago; Thacker, Cincinnati, and Fulton, St. Paul.

NEWS.

—A new medical club, called the "Galen Club," has been founded in London.

—Dr. Charles Croker King died in London, February 25, of gangrene of the foot.

—A polyclinic has been organized in New Orleans. The first course of lectures will begin April next.

—The Fothergill prize of the Medical Society of London has been awarded to Dr. Hobart A. Hare, of Philadelphia.

—Dr. W. W. Godding, of Washington, thinks there is no truth in the popular belief that fish is of value as a brain food.

—Dr. Bayley Balfour has been appointed Professor of Botany in the University of Edinburgh. His father occupied the same chair from 1845 to 1878.

—At the 32d annual commencement of the Philadelphia College of Dental Surgery March 1, 1888, the degree of Doctor of Dental Surgery was conferred on 58 graduates.

—On December 31, there were 1,200 persons in the Philadelphia Hospital, who required medical or surgical treatment. At the same date there were 164 persons in the Pennsylvania Hospital.

—At the invitation of Dr. Thomas Wistar a reception was given at the rooms of the Penn Club, March 8, to the Board of Managers of the Philadelphia Dispensary. A number of eminent physicians either are or have been connected with this dispensary.

—Dr. W. A. Swiers, who was graduated at the Jefferson Medical College in 1883, was convicted of abortion at Brookville, Pa., on February 14, 1888, and was sentenced to pay a fine and undergo an imprisonment of five years and three months.

—A raid, says the *Lancet*, March 3, 1888, has been made on a number of persons in Frankfort who have been describing themselves as dentists and American dentists without any legal right to do so. They have been obliged by the police to take down their sign-boards.

—Dr. E. B. Halliday, alias Stevens, who says he is a graduate of the University of Vermont, was arrested February 22, in Philadelphia, on the charge of forgery. The police authorities say that Halliday left the city in 1886, after obtaining the money on a check for $300, purporting to be from Bullock & Crenshaw, and only returned several days ago.

HUMOR.

GENTLEMAN (to consumptive friend)—"You walk very slow, Sam." Sam—"Yes, but I'm going very fast."—*Tid-Bits*.

TALMAGE ADVERTISES for a text for his sermon before the dental convention. How about "The noise of the grinders is low?"

MRS. VERBOSE: I dread typhoid more than any disease I know of.

Mr. Verbose: Typhoid! You surprise me! I should think lock-jaw would be your *bête noir*.

MAMMA—"Look Cissy, here comes the doctor! What a favorite he is. See, even the little chickens run to meet him." Cissy—"Yes, ma, and the little ducks cry 'quack, quack!'"—*Medical Herala*, Feb. 1888.

A NEW YORK DOCTOR claims that it is not a physical necessity that men should die. It is a bad habit that men have got into, however, and a very hard one to overcome, especially when they are so ably assisted by the doctors.

AN AWFUL BLUNDER.—Druggist (in alarm)—"James, run to Mrs. Smith's at once; I've made an awful mistake!" James (seizing his hat)—"Morphine—quinine—arsenic—poison——" Druggist—"No, no; she sent for ten cents' worth of one-cent stamps, and I sent her ten twos!"—*The Sun*.

JOE—"How did young Jones happen to get shot?"

Eli—"You see, he held a penny between his fingers for one of those western fellows to shoot at—"

Joe—"And he got his hand shot off?"

Eli—"No; he got hit in the left foot."

THE FOLLOWING was recently turned in as a bona fide composition by an Indiana schoolboy: "The human body is made up of the head, the thorax and the abdomen. The head contains the brains, when there is any. The thorax contains the heart lungs and diafram. The abdomen contains the bowels of which there are five, A, E, I, O, U, and sometimes W and Y."

THE SHERIFF at Mobile, Ala., resorted to rather novel means to overpower a rebellious prisoner. Armed with a dirk, the belligerent defied the prison officials to remove him to the dark cell, whereupon a neighboring fire company was ordered to turn a stream upon him. While he was vainly attempting to dodge the ice cold water the officials rushed upon and overpowered him.

ANXIOUS FRIEND: "My dear fellow, what are you doing at an open window with your coat off in such bitter weather? You will certainly be sick!"

Reckless friend: "I hope I will; my landlord is a doctor, and if I don't give him something to do he'll put my rent up!"—*Fliegende Blätter.*

PRACTICAL DARWINISM.—A Paris physician, says the Paris correspondent of the *Chemist and Druggist*, February 4, 1888, asked for permission to try a new treatment for consumption on the monkeys kept in the Jardin d'Acclimation. The establishment has many such inmates suffering from phthisis, as is the case with most monkeys brought to Europe, and the doctor thought he could cure them. Although he assured the director that his treatment was perfectly harmless, the permission was refused. Some of the physician's *confrères* say the reason of the denial is probably because the medicines had not previously been tried on the monkeys' more common and less valuable brothers, namely, men.

WHAT AILED SMITH.—A plainly dressed man, who introduced himself as Mr. John Smith, walked into a doctor's office, and having explained his symptoms, asked the doctor how long it would take to cure him. The doctor, who had treated the visitor with every possible courtesy, replied: "You will require several years' careful treatment under my personal supervision before you are perfectly well; but I think, Mr. Smith, that you will be able to resume your labors in the bank in about two months." "Doctor, you are fooling yourself; I am not Smith the banker, but Smith the street-car driver." "Is that so. Well, my good fellow, I don't see what you came to me for. There is nothing the matter with you except that you are not a banker."—*Texas Siftings.*

OBITUARY.

S. A. FOSS, M.D.

Dr. S. A. Foss died near Pleasure Ridge Park, Kentucky, Feb. 15, in the 67th year of his age. He was graduated at the Medical Department of the University of Buffalo in 1847.

THOMAS F. AZPELL, M.D.

Dr. Thomas F. Azpell, of the United States Army, senior captain in the service, died at Fort Lee on March 12. Dr. Azpell was born in the city of Philadelphia, and was graduated at Jefferson Medical College in 1849. He practiced his profession in Philadelphia until the breaking out of the Rebellion, and was said to be the first volunteer surgeon mustered into the service. After the three months' campaign he was transferred to the regular army, and subsequently rendered efficient service in the West. At the close of the war he was assigned to duty in the Shasta Valley, and remained in active service until his retirement, three years ago. His illness was very brief, as his health had been impaired by injuries which he received in the Modoc war.

THOMAS DELANO SWIFT, M.D.

Dr. Thomas D. Swift died in New York, March 3, in the 35th year of his age. He was graduated from the College of Physicians and Surgeons, New York, in 1879.

BYRON W. CHEEVER, M.D.

Professor Byron W. Cheever, A.M., M.D., Professor Metallurgy in the University of Michigan, died at Ann Arbor, March 6. He was graduated from the Medical Department of the University of Michigan in 1867.

Official list of changes in the Stations and Duties of Officers serving in the Medical Department, U. S. Army, from March 11, 1888, to March 17, 1888:

Major G. M. Sternberg, Surgeon, ordered to proceed to Brunswick, Ga., on official business, and upon completion of same will return to his proper station. S. O. 57, A. G. O., March 10, 1888.

First Lieutenant William D. Crosby, Assistant Surgeon, granted leave of absence for two months, with permission to apply for an extension of one month, to take effect after being ordered to a new station. S. O. 60, A. G. O., March 14, 1888.

First Lieutenant Jefferson R. Kean, Assistant, Surgeon, relieved from duty at Fort Sill, Ind. Ter., and ordered for duty at Fort Robinson, Neb. S. O. 56, A. G. O., March 9, 1888.

Changes in the Medical Corps of the Navy, for the week ending March 17, 1888:

Passed Assistant Surgeon W. H. Rush, detached from Navy Yard, New York, and to Naval Hospital, Philadelphia, Pa.

Passed Assistant Surgeon, J. M. Steele, detached from Naval Hospital, Philadelphia, and to Coast Survey Steamer "Bache."

Medical Inspector A. S. Oberly, detached from Navy Yard, Portsmouth, N. H., and wait orders.

Surgeon, F. L. Du Bois, ordered to the Navy Yard, Portsmouth, N. H.

Assistant Surgeon, James Keeny, ordered to the Receiving Ship "Minnesota."

Passed Assistant Surgeon C. W. Deane, detached from Marine Rendezvous, San Francisco, and to Coast Survey Steamer "McArthur."

Assistant Surgeon, E. W. Auzal, detached from Coast Survey Steamer "McArthur," and to Marine Rendezvous, San Francisco.

Passed Assistant Surgeon Clement Biddle, ordered to Naval Academy, Annapolis, Md.

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Communications.

THE DISEASES OF THE STOMACH, AS JUDGED BY A NEW CHEMICAL REAGENT.[1]

BY PROFESSOR GERMAIN SÉE,

MEMBER OF THE FACULTY OF MEDICINE, PHYSICIAN TO THE HOTEL DIEU, PARIS, FRANCE.

[Professor Sée, having alluded to the difficulty of diagnosis of chronic affections of the stomach by the ordinary methods, and the unsatisfactory nature of some of the tests of the acidity of gastric juice employed, remarked that he had found Gunzburg's new reagent, the *phloroglucine vanillin test*, to perfectly meet the want of a delicate and sure test of the presence of hydrochloric acid in the gastric juice. He then spoke as follows.]

An important group of gastric diseases comprehends the cancers, the ulcers, the amyloid degenerations (which are rare), the scleroses or indurations of the sub-mucous tissue, the atrophies of the walls, and lastly, the lesions of toxic, and especially alcoholic origin. All that does not enter into this grave category has been classed under the name of dyspepsia. Formerly this term was applied to almost any gastric disorder—to gastralgia, to flatulence and even to vomiting, although the latter does not always imply a disturbance of the digestion. Dyspepsia was then merely a symptom-entity. Afterwards came Broussais with his famous doctrine of gastritis, which included a multitude of morbid conditions. This view, making dyspepsia an inflammatory trouble, was soon abandoned by reason of its absurd complications, and gave place to the *primordial dyspepsia* of Beau, a stupendous pathological bugbear, supposed to give rise to a variety of complaints—to chlorosis as well as anæmia, to tuberculosis and to cancer. This new notion soon came into discredit, and the German pathologists substituted for it that of mucous catarrh of the stomach—the word dyspepsia was erased from nosology. But the last word was not yet said. During the last eight years a vast amount of scientific investigation has been going on, which has put to the test accepted theories, and pretty effectually cleared up the mysteries connected with this subject. In my treatise on "Gastro-Intestinal Dyspepsias," (second edition, 1883), I have endeavored to demonstrate two facts:

1. That dyspepsia is always and necessarily a defective chemical process, due to some alteration of the elements of the gastric juice, and especially of the hydrochloric acid; the gastric juice may, moreover, be imperfect by reason of inertness of pepsin, or by reason of excess of peptones formed, or of mucus preformed, all of which retard the digestion. This constitutes dyspepsia proper. At the last three Congresses of German physicians, Van-der-Velden, Leube, Riegel, Ewald and Boas, Edinger and Jaworski, have endorsed, without giving me credit for my own researches and conclusions, this chemical view of dyspepsia, adopting principles of pathogenesis and a classification which I have long taught.

2. The second fact which I endeavored to bring prominently to light at the epoch when I published my book, was this: All the properties of the stomach which do not belong to the domain of chemistry, such as the sensory and motor innervation, are simply auxiliaries to true digestion; they may, in fact, undergo grave modifications without any real digestive trouble resulting.

[1] A paper read before the Academy of Medicine of Paris, January 17, 1888.

When the gastric innervation is impaired, there ensues a series of perturbations which often simulate the phenomena of dyspepsia, and to such an extent as to render the distinction very difficult; we have, however, to do in these cases only with nervo-motor states, with atony or spasm of the stomach.

Diagnosis of Chemical Dyspepsia.

Let us now inquire what are the chemical alterations which constitute true dyspepsia. First and foremost, we need to ascertain if the acids of the stomach, and especially hydrochloric, are deficient or lacking. To attain this end, and in order to obtain gastric juice, physiologists no longer rely on gastric fistulæ practiced on animals, or on accidental fistulæ, the results of wounds in man, for the subjects of these lesions always have the stomach exposed by an external opening, so that its condition has become in some sense pathological. Nothing can be considered as exact so long as the analyses do not pertain to the gastric secretion of a healthy man, or one with the stomach intact. Twenty years ago we used to employ Kussmaul's stomach-pump to obtain gastric juice; we now use a soft rubber tube, not much larger than a catheter, which is connected with an aspirator, and by this the juice is collected before and during digestion. Leube injects ice water before a meal, in order to provoke the gastric secretion, then extracts the gastric juice by means of the soft tube and aspirator. Jaworski and Gluzinski obtain the juice by a similar procedure, injecting water at 64.4° F., and aspirating the contents of the stomach after fifteen minutes. Ewald and Boas do not dilute the gastric liquid; they facilitate its extraction by means of pressures made over the abdominal and epigastric regions. I employ a similar method, as we really need but a few drachms of the gastric juice for purposes of testing. I make use of Potain's apparatus with pressure over the stomach; after a few short aspirations the liquid rises from the stomach into the receiving bottle, and is pure from any admixture with water. Durand-Fardel, my clinical chief, operates in a similar manner, obtaining by means of an incomplete vacuum the small quantity of pure gastric juice required, and without in any way injuring the stomach.

Reagents.

The reagents employed for investigation of the acids of the stomach are tropéoline, methyl violet, ferro-sulpho-cyanide of potassium, the phenic perchloride of iron, and the phloroglucine-vanillin test of Gunzburg; the Congo-red should also be mentioned.

1. Tropéoline, or Orange No. 4, first proposed by Van-der-Velden, is a concentrated aqueous yellowish solution, which becomes bright red under the influence of the least trace of acids. 2. Methyl violet was introduced by Laborde as a good test for lactic acid, which he considers the predominant acid in the stomach, being formed there, as well as hydrochloric acid. A few drops of this reagent, according to Laborde, gives with the contents of the stomach, if lactic acid be there, a pale blue, becoming deep blue. 3. If the acidity of the stomach be from the acids of fermentation (such as sarcolactic acid), it is best recognized by ferro-sulpho-cyanide of potassium, which decolorizes the matters from the stomach. In a liquid form the stomach containing only two to four tenths per cent. of acids, especially of Hcl, the above reagents reveal the presence of the latter, while lactic acid only gives the coloration if in considerable quantity. In the latter case, as well as when the acidity is due to fatty acids (butyric acid, etc.), the best test is the phenic perchloride of iron, which gives an ash-gray color.

Now we know, according to the researches of Ewald and Boas, that during the first thirty minutes of digestion, lactic acid predominates, being formed prior to hydrochloric; then the two acids exist together (experiments of Berthelot and Richet); then there is a phase exclusively hydrochloric, which begins sometimes after half an hour, sometimes after an hour. This applies only to healthy states; in certain morbid states the digestive periods, and especially the lactic phase, are greatly prolonged. The existence of these phases, which I have called the *amylolytic period* and the *hydrochloric period*, brings confusion into our researches, for our reagents cannot enlighten us as to the relative proportion of mineral acids and organic acids. Here the recent discovery of Gunzburg comes to our help, his phloroglucine-vanillin test constituting the surest and most expeditious reagent. Gunzburg got the hint from Wiesner, who had observed that pine wood soaked in a solution of phloroglucine and moistened in strong hydrochloric acid, takes on a deep red color. Now the substance which with phloroglucine and Hcl gives the red stain, is vanillin. Two grammes (thirty grains) of phloroglucine, and one gramme (fifteen grains) of vanilline, with thirty grammes (nearly one oz.) of absolute alcohol, give a reddish yellow solution. One drop of this solution in presence of even a trace of a con-

centrated mineral acid, takes on immediately a bright red hue, while at the same time beautiful red crystals are deposited. The organic acids, as lactic and acetic, give only negative results in presence of this reagent. If the proportion of the mineral acid present is very minute, it will be necessary to slowly evaporate the liquid in a porcelain crucible; you will then get a deposit around the edges of fine red crystals. For this purpose you should use a spirit lamp, and take care that the liquid which you are testing does not boil. In testing gastric juice, you take a few drops of the fresh liquid from the stomach, filter, and add as much of the phloroglucine vanillin solution; evaporate with the precautions mentioned, and you will obtain the color reactions above described. When the gastric liquid contains considerable quantities of albuminates or peptones, the isolated crystals are not observed, but the bright coloring persists, and the crucible is covered with a mixture composed of albuminates and fragments of crystals.

[Prof. Sée further stated that this test is only of value as giving a proximate rather than an exact estimate of the proportion of hydrochloric acid in a given quantity of gastric juice. There are all shades of color, from faint to deep red, corresponding to a minus or plus quantity of Hcl in the gastric juice under examination. Moreover, the test is especially valuable in revealing the presence of mineral in contradistinction to organic acids. The professor then took up the subject of the time most appropriate for obtaining gastric juice. Leube extracts gastric juice seven hours after a hearty meal of soup, beef steak and bread; Riegel aspirates the gastric fluid five hours after a meal when the stomach is full. Professor Sée's method is as follows:]

"Instead of commencing the test at the end of fifteen minutes, and repeating it every quarter of an hour till four or five trials have been made (method of Jaworski and Gluzinski), a procedure which is very trying to the person under examination, I practice the extraction of the juice at the end of forty-five or sixty minutes after a meal; then, instead of administering ten ounces of liquid, I permit the ingestion of only a very small quantity of water, and in this way I am sure to obtain several drachms of gastric juice, which is quite sufficient for purposes of testing. I use now no other tests, repeating the examination the next day with Gunzburg's reagent, and perhaps the following day, till satisfied as to the acid quality of the gastric juice."

Application of the chemical data. Digestive troubles without chemical fault. —If now we apply these data to the divers diseases of the stomach, we shall see the pseudo-dyspepsias or nervous dyspepsias form a class apart from the chemical dyspepsias, properly so called. There are individuals who, with a normal proportion of Hcl in their gastric juice (0.15 to 0.2 per cent.), experience manifest digestive disorders—a sensation of pressure or of pain at the epigastrium, fulness after eating, gaseous eructations, capricious appetite, with absence of vomiting, regurgitations and emaciation. Chemical examination of the gastric juice shows, besides hydrochloric acid, lactic acid, sometimes in normal, sometimes in abnormal quantity. Digestion is especially painful after the ingestion of food of a heavy, "hearty" character; while light food, and especially amylaceous food, gives little trouble. These are "nervous dyspepsias," cases of atony of the stomach, or simply gastro-intestinal neuroses. Now for the positive data:

First Group. *Anachlorhydric secretions.* —A first group comprehends the anachlorhydric secretions; a second group, hydrochloric excess; a third group, the variations. From recent researches the fact is brought to light that the diminution or absence of the gastric secretion is not as frequent as was formerly taught. Thus, even in fever, true acid gastric juice is not completely wanting. In reality, we may reduce to two the morbid affections which are attended with a minimum of hydrochloric acid in the gastric juice: 1, carcinoma of the stomach, with or without dilatation, and perhaps atrophy or amyloid degeneration of the organ: 2, certain dyspepsias called mucous dyspepsias, and especially those which result from inanition, from marasmus, which constitute the most common kinds of dyspepsia.

Cancers.—[Prof. Sée remarked that all authorities of late years—Riegel, Van-der-Velden, Ewald, etc., have testified to the absence of Hcl in cancer of the stomach. Riegel attributes this to a specific and destructive action of the cancer juice, and to concomitant mucous catarrh. The same absence (which is not, however, absolute) has been noticed in amyloid degenerations and atrophies of the stomach, and in sclerosis.]

Mucous dyspepsias.—After carcinoma the morbid condition, which seems most to arrest the production of hydrochloric acid secretion, is mucous catarrh. It is certain that at the onset of the disease, hydrochloric acid is present; when later there are lesions of texture, as well as atrophy of the glands,

and interstitial deposits, the acid secretion is no longer capable of demonstration.

Dyspepsias from inanition and marasmus.—It is certain also that the production of Hcl may be wanting in all cases of marasmus, as well as after grave hemorrhages, etc. This absence has been repeatedly noticed in tuberculous, uræmic, and diabetic dyspepsias.

Second group. *Digestive troubles with hyper-secretion of gastric juice, or hyper-acidity.*—While gastric disorders with diminished or suppressed secretion are rarer than was once supposed, it has recently been shown by painstaking chemical researches that excess of hydrochloric acid secretion is one of the most common occurrences. In 200 cases of dyspepsia, Boas noted this hyper-secretion in 60. The dyspepsia from excess of acid is quite different from that in which acid is deficient. The distress is intimately connected with the act of digestion, and does not begin immediately after the introduction of food, but after the end of half an hour, an hour, or even later. What these patients principally complain of is the highly acid regurgitations of food, belchings of sour gas which comes up into the throat and mouth; there are, withal, burning sensations along the œsophagus, and severe pains, often of a piercing character, sometimes referred to the pit of the stomach. The appetite is feeble or *nil*, the tongue heavily coated, the bowels constipated, and in an advanced state of the disease, the patient is much emaciated. The analysis of the gastric secretions after a test meal, shows that this train of symptoms depends on excess of hydrochloric acid production; it is not even rare to note 0.4 to 0.5 per cent. of Hcl present. The organic and volatile acids are more or less completely wanting. In this kind of dyspepsia the digestion of proteinaceous matters is well accomplished; it is even probable, considering the rapidity of peptonization, that the presence of peptones in excess hinders the rest of the digestion. The digestion of starchy food is, however, impeded; for with more than one-tenth of one per cent. (0.1) of Hcl in the gastric juice, maltose ceases to be formed. If, in fact, we give to these patients an amylaceous mixture, and examine after an hour the filtered liquid from the stomach, we find plain evidence of *incomplete saccharification:* a solution of iodide reveals the presence of *erythro-dextrine*, while in the normal state we ought to find *achro-dextrine*, or even maltose.

Chlorhydric dyspepsia.—It is rare that the digestive disorders are any worse than those above described; but with excess of secretion the dyspepsia becomes *chlorhydric;* there is even sometimes a permanent hydrochloric-hypersecretion, so that in the morning when the stomach is empty, you will obtain by aspiration several drachms of liquid containing Hcl in abundance, and capable of digesting albumen. This form has been described by Reichman, Jaworski and Riegel, who found in four cases of this kind, a marked dilatation of the stomach, resulting, doubtless, from prolongation of the digestive process.

Résumé.—Without speaking of nervous dyspepsia, in which the gastric juice is normal, there exists a dyspepsia with deficiency of hydrochloric acid, and a dyspepsia with excess of hydrochloric acid; the latter may go on to constitute a *permanent hyper-acid dyspepsia.* But the etiological conditions of these acid dyspepsias are unknown; we know only that the dyspepsias characterized by excess of acidity are often associated with hæmatemesis, and consequently, with ulcer of the stomach. We know, moreover, that these dyspepsias oftentimes rest on a chlorotic basis; chlorotic patients are quite subject to attacks of cardialgia, which marvelously get well under alkalies given in enormous doses. A patient of this kind is now under treatment in Ward St. Jeanne, Hôtel Dieu.

Third Group. *Gastric juice secretions variable as to hydrochloric acid.*—This group includes dilatation of the stomach, of which so much has been said of late years. I am of opinion that this dilatation is not a primordial disease of the stomach, but only a symptom more or less pronounced of divers affections of the stomach, or, what is more frequently the case, of divers morbid states of the intestine. Moreover, the signs of gastro-ectasis are very uncertain, and in my experience are often referable to dilatation of the transverse colon. In doubtful cases, Ehrlich advises, in order to assure one's self that dilatation of the stomach exists, to give the patient salol in doses of fifteen or thirty grains. In the normal state this medicine passes intact from the stomach to the intestine, where it is mostly broken up by the pancreatic juice, then absorbed and eliminated at the end of an hour by the urine; if the salol does not appear till much later in the urine, it is because the stomach is dilated and retains the medicament. I have found four kinds of causes: 1. Fibrous or cancerous stenosis of the pylorus. 2. Atony of the gastric walls (through muscular enfeeblement). 3. Atony of the intestines, affecting the pylorus, and allowing gases to pass into and distend the stomach. 4. Intestinal

dyspepsia—simple chronic (mucous or membranous) entero-colitis, from which result gases by decomposition of the contents of the intestine, then pyloric insufficiency, and distention and dilatation of the stomach.

In five cases the gastric juice presented marked variations; in pyloric stenosis, there was no hydrochloric acid; in simple atony direct or consecutive, the acid was not lacking; less is known concerning the results of intestinal dyspepsia on the gastric juice. Out of thirty-three cases of dilatation studied by Riegel, twenty-one were simple; in none of these cases was the acid wanting, and in all the peptic force of the gastric juice was intact. Riegel has not made sufficient account of the influence of the intestine in producing dilatation. At any rate we may affirm that dilatation of the stomach is not destined to embrace or take the place of that dyspepsia which Beau considered the source of all evils; dyspepsia and dilatation are quite distinct, and dilatation may exist a long time without producing dyspeptic troubles. Nevertheless, in old dilatations, the gastric contents may undergo putrid changes, and thus a kind of "putrid dyspepsia" result.

Observations.—[Prof. Sée gives reports of sixteen cases in which examinations of the gastric juice were made. The first group comprehended cases in which Hcl was absent: *i.e.*, two of cancer of the stomach, two of tuberculosis (pulmonary phthisis), one of heart disease, one of diabetes, one of dyspepsia in an old paralytic patient, one of dilatation of the stomach of long standing, and one of gonorrhœal rheumatism. This group he calls the *anachlorhydric group*. The second group, which he calls the *hyperacid group*, comprehended one case of muco-albuminous enteritis of long standing, and another of dyspepsia from anæmia. The "normal group" contains two cases of simple dilatation with enteritis, one case of chronic gastro-ectasia without emaciation, and one of intestinal dyspepsia.]

Interpretation of the Anachlorhydric or Negative Digestions.

The fact that hydrochloric acid is wanting in the gastric secretion is no reason for the conclusion that the digestive process is a total failure. The stomach may lack the ability to do its work, and yet the intestinal digestion may be well performed, and the general nutritive functions may be still kept at the normal level. In cases of this kind, the stomach is only a place of transit for the food, and has no function but one of a motor kind,—"churning" and expelling the aliments; almost the entire amount of albuminates ingested escapes from the stomach before being peptonized, for the reason that no hydrochloric acid is secreted, and such gastric juice as the stomach produces acts only by virtue of the organic acids which it contains, and does not accomplish the peptonization of foods; the real labor of digestion devolves on the intestine.

A second cause favors the deterioration of the gastric juice, and the lessening or suspension of hydrochloric acid formation, namely, a vitiated state of the blood: the diabetic, the nephritic, the cardiac, the tuberculous dyspepsias are cases in point. Why these conditions interfere with the production of normal gastric juice is not well understood. At the same time, patients afflicted with these diatheses do not always suffer from indigestion; the intestinal digestion may be normal, and make up for the deficiency on the part of the stomach, and the general nutrition may be kept good. As soon, however, as uræmia or glycæmia, or venon stasis from cardiac failure or tuberculosis affects the intestine, diarrhœa, dependent on some one of those conditions, sets in, and sweeps off the products of digestion before their absorption; then the supplementary digestion having failed, malnutrition and emaciation rapidly follow.

There is a third class of cases, common enough in connection with anachlorhydric digestion. There are real gastric troubles—flatulence, slowness of digestion, pyrosis, pain and discomfort in the stomach, and nervous symptoms of a depressive kind. Hydrochloric acid is wanting, but the motor functions of the stomach are also at fault. The pancreatic and intestinal juices may even here compensate what is lacking on the part of the stomach, the liver may do its work well, and the patient may not seriously suffer from denutrition. In cancer of the stomach, all the functions of the stomach, chemical as well as nervo-motor, are compromised, while the production of the intestinal juices is suspended by the starving of the glands; the function of absorption by the lymphatics in both stomach and intestines is in abeyance, so that foods are neither transformed nor assimilated. On the other hand, in simple chlorhydric dyspepsia, the resources of the intestine suffice for the entire performance of digestion.

[Prof. Sée spoke of certain dyspepsias which are often misunderstood, and which are properly intestinal. The chemical functions of the small intestine may be disordered, or the large intestine may be in a

state of atony. There is pain at the pit of the stomach, and distention of the abdomen with gas, which sometimes forces the pylorus; the patient suffers from constipation, alternating with diarrhœa, cerebral and nervous troubles, severe dyspeptic discomfort three or four hours after a meal. The atony of the colon may result from simple "muscular debility," or a mechanical obstacle to the expulsion of the contents of the bowel, *e. g.*, tumors of the womb, or retroversion, hemorrhoids, hernia, etc.]

Bradypepsia.—There are cases which neither come under the category of chemical dyspepsia of the stomach, nor atony of the intestine, and which are characterized by simple retardation in the stomachal digestion; these are included under the head *bradypepsia*. We know, in fact, that the fragments of albumen in normal digestion appear, at the end of from thirty to sixty minutes, as if gnawed at their borders; we know that if the gastric juice is feebly acid, or neutral, or even alkaline (as is the case with the crustaceæ), the blocks of albumen remain unaltered till the moment when they pass the pylorus. This passage ordinarily takes place when the reaction of the gastric juice is at its maximum—then the larger part of the albuminous substances quit the stomach, and liquid extracted from the stomach at this time contains neither peptones nor acids.

But in the pathological stomach the time of expulsion of the morsels of albumen may vary from fractions of an hour to an entire night. In mucous dyspepsias, in dilatations of the stomach, there is a marked retardation. This slowness of the digestive act is not an indigestion, for the final result is good, and the food ends in being digested, peptonized and absorbed.

Treatment.—The common treatment of these gastric affections may be comprised under the three following heads: *Chlorhydrotherapy*, *Alkalinotherapy*, *Evacuants*. With regard to the administration of hydrochloric acid, I have always had grave doubts as to the utility of this medicament, despite the authority of Trousseau; certainly hydrochloric acid pure or associated with pepsin, cannot be regarded as indicated in the dyspepsias attended with hypersecretion of this acid, and these cases are very common. But it is necessary for one to be on his guard against mistaking for signs of acid dyspepsia, the patient's sensation of pyrosis, or of "burning gases," for in these cases the gastric juice may be neutral, or feebly acid. The only way to solve the question is by the stomach syphon; if hydrochloric acid is in abundance, the free administration of this acid can have only injurious results. We may go even further and say that when hydrochloric acid is wanting, or is present in very small proportion, as in cancer of the stomach, even here the administration of this acid medicinally does no good, for there is no formation of gastric juice, even in presence of the hydrochloric acid. Experience, moreover, proves its uselessness and, I may add, its danger.

The true province of chlorhydrotherapy is dyspepsia with deficiency of acid, or with predominance of the organic or volatile acids, and even in dilatation of the stomach with excess of organic acids. The dose in these cases would be twenty drops of the dilute acid in a little water, to be taken twice or three times a day during the course of the digestion, or after meals.

Alkalinotherapy.—This mode of treatment is still under discussion, at least, as far as the dosage is concerned. Generally, too small doses are given; what we want to do is to neutralize the excess of acid. To determine this excess of acid in a given case, you must aspirate a certain quantity of gastric juice after a test meal, and ascertain the quantity of Congo red necessary to neutralize the filtered gastric fluid. You add bicarbonate of soda till the Congo red turns feebly blue. A quantity in excess of the amount calculated should be used, as carbonate of sodium solutions are rapidly absorbed from the stomach. A proper prescription would be from one drachm to a drachm and a half of sodium bicarbonate dissolved in water, to be taken between meals, and continued for several days.

Evacuants.—These medicines are applicable to all cases of atonic affections of the stomach and intestine. If dilatation of the colon be the cause of the gastro-ectasis, *lavage* of the stomach is indicated as a therapeutic measure. If the intestine provokes pseudo-dyspeptic stomach symptoms, purgatives and laxatives are indicated. Purgatives have long had a reputation for being beneficial in gastric complaints. Why this is I know not, unless the dyspepsias under treatment were pseudo-dyspepsias, having their seat in the intestine.

Regimen.—Milk is prescribed at the present day everywhere (*urbi et orbe*), whether the practitioner have to do with an organic disease of the stomach, or a true gastric dyspepsia, a dilatation of the stomach, an atony of the intestine, or a muco-albuminous enteritis. In any and every one of these cases

you are almost sure to see the milk diet ordered, and often to the exclusion of all other treatment. [Professor Sée condemned this treatment as not giving the best results, and as being often irrational; the milk diet is good in diarrhœic complaints, and is the proper treatment—in fact a *sine qua non*—in ulcer of the stomach.

Another regimen commonly prescribed in dyspepsias, consists of light, tender, juicy meats, with little or no vegetables—starches and fats being forbidden. This regimen may lead to inanition, elements needed for nutrition being withheld. Such a diet has a temporary utility in patients whose gastric juice is poor in Hcl, *e.g.*, mucous dyspepsia, gastro-ectasis complicated with mucous dyspepsia.]

Amylaceous regimen.—In mucous dyspepsias and even in cancer where hydrochloric acid is totally lacking, it is useless and often dangerous to deprive the patient of food principles contained in the starches, and especially of such dietetic substances as are both amylaceous and nitrogenized. In conditions in which hydrochloric acid is in minimum proportion, the amylolitic period of digestion is predominant and rapid, and considerable absorbable maltose is formed with facility. In such cases soups with rice, etc., may be permitted, and also bread and biscuit; fat should be in sparing quantity, or withheld altogether; sometimes potatoes roasted in the ashes may be given, and pea soup or bean porridge.

Meat regimen.—A diet of starchy food ought to be rigorously interdicted in dyspepsias with hypersecretion of hydrochloric acid. Such articles of food are not transformed by the gastric juice; the excess of acid may determine spasm of the pylorus and retention of the amylaceous substances in the stomach, or exaggerated contractions of the muscles of the stomach, causing expulsion before the time, of the incompletely transformed or fermenting aliments. Fresh meat and fish are indicated in these cases, and the patient should virtually live on this diet—beef, mutton, fish, lean ham, in preference to fowl, game or veal. As for *beverages* in dyspepsias, those with hyperacidity are the worse for wine, and tea should be used instead. While fermented liquors are to be avoided, whiskey and brandy in moderation seem to do no harm, except to occasion a slight retardation of the digestion. [In dyspepsias with deficiency of gastric juice, on the other hand, wine is often an advantage by promoting an acid secretion.]

ON EXERCISE FOR THE PREVENTION AND CURE OF DEFORMITIES.

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Its my object in this note to briefly call attention to what may be done by means of exercise for the prevention and cure of bodily deformities. Let me first say, however, that there is a difference between exercise and "athletics." The latter is a variety of the former. The one is usually either a sport or a business, and only sometimes an "exercise," while the other, if judicious, may be considered a therapeutic and prophylactic remedy of incalculable value. A wrong conclusion must be drawn if, in passing judgment upon the therapeutic value of exercise, our knowledge of its good effects is based only upon what little has been written on the subject. Too few of those qualified for the work have ever made it the object of their main efforts.

It is common enough to hear of the bad effects of over-exercise. Now is this not suggestive? Is not a remedy that is productive of evil also potent for good? If exercise, for instance, will cause an abnormal enlargement of the heart in health, is it not rational to assume that it will strengthen a heart that is abnormally weak? The heart is but a muscle, and what is true of other muscles in this regard is also true of it.

On *a priori* grounds, therefore, it would seem that exercise may be productive of good, especially when there is defective strength and muscle development. When we recollect that muscles never contract without acting upon other parts, we are compelled to admit that those other parts may also be influenced by exercise. For instance, increased muscular action causes increased heat production. It causes tension of the periosteum and bone to which the motive muscles are attached. Thus hyperæmia results, and bone growth is encouraged. Again it affects other structures, as for instance, the heart and lungs (circulation and respiration), by chest expansion, due to raising of the ribs when the proper muscles are contracted.

Deformities are treated by means of braces, supports and elastic bands—*artificial muscles*. These all weaken still more an already feeble muscle. How much better it would be to develop the weaker parts and so relieve the patient in a manner that is at once inexpensive, not unpleasant or ungainly, and that will insure a permanent cure.

But what has been done, and what can be done? is the important query. My experience with properly selected cases has been almost uniformly successful. Among them may be mentioned cases of spinal curvature, club-foot, malposition of parts (as for instance inversion of the toes), pigeon breast, flat chest, and others.

My opportunity for observation at the University of Pennsylvania is a great one, and it has been my good fortune to see young men and boys much benefitted by judicious exercise. Two cases of pigeon breast in boys under my care were much modified in less than three months by a judicious course of gymnastics. Mr. W. B. Page, at present a post-graduate student at the University of Pennsylvania, became the greatest high jumper the world has ever known, because he had *weak legs* in infancy and undertook to strengthen them by *exercise*.

In the summer of 1885, I had under treatment a young professional man much given to hard intellectual work, of sedentary habits, extreme disinclination for physical exercise, possessed of an ever-present feverish restlessness, and who was for years a sufferer from insomnia. His appetite, though for years voracious, gradually failed and left him a dyspeptic. He was tall, thin and flabby, had a weak heart and quick feeble pulse, often dicrotic in character. He was strongly urged to exercise in the open air. He impatiently gave it an unfair trial, consisting of over-exertions at irregular intervals. In the fall he developed a bronchitis that persisted despite the best treatment and a rest out of town and away from all care. In the latter part of February, 1886, he again took up his out-door exercise, and kept it up steadily with the result of getting into fine physical form at the end of the season, when he was wiry and minus fat, and when stripped reminded one of a race-horse. All his muscles were hard, his girths and weight had increased slightly; his mental and physical vigor had undergone a revolution; his appetite was very good and his insomnia gone. This is but one instance of a general restoration by suitable exercise of a worn-out body and mind.

A boy, 11 years of age, was brought to me in the summer of 1881, with posterior and left-lateral spinal curvature. He had had no appetite for about six weeks. He was pale and emaciated, having, according to my knowledge, greatly fallen off in those few weeks. His forward stoop and inclination to the right had been noticed for some time, but its onset had been so insidious that neither patient nor parents could fix a time for its beginning. He looked cachectic and had a family history of tuberculosis on both sides. He had been to school since six years of age, and was remarkably bright, advancing rapidly in all his studies, and was the pride of all his teachers. The treatment of this boy consisted in the internal administration of the syrup of the iodide of iron in half drachm doses t. i. d., and suitable exercises. A plaster jacket was not applied because of the fear that it might prove so oppressive in the hot weather as to debilitate him still more. The exercises consisted in hanging from a horizontal bar by both hands many times a day, at first for about a few seconds, the time being lengthened as the strength increased. During the intervals he spent most of the time at full length and on the flat of his back on a hard lounge with his hands and arms extended over his head. He was dieted so as to conserve as far as possible his nervous and digestive energies. In less than two months he was practically well, had a good appetite, ruddy cheeks, bright eyes, a somewhat rounded outline, and a *straight* column. The exercise was continued, however, for months afterward.

In the middle of October, 1887, I was consulted about a bright and healthy boy a little over two years old. He turned both toes in while walking or standing. Two or three physicians had been consulted, and one orthopædic surgeon, with the same result, which consisted in the advice to have braces applied to force the feet into proper position. This the parents were loth to do and asked me to suggest some other means worthy of trial. The boy required absolutely no general treatment whatever, for his health was perfect. I advised three exercises. One was to stand upright with the inner side of the shoes touching from heel to toe; then, while the heels remained in contact, the toes were to be turned out as far as possible, held there for a moment, and then returned. This was to be repeated *ad libitum* as an *amusement*. The second consisted in standing with the outer side of one foot against the wall and pressing the side and end of the foot forcibly against the wall. The third consisted in lying upon the floor at full length, back down, and everting both feet to the utmost extent, attempts being made to as nearly as possible touch the floor with the outer side of each foot. The object was in all these movements to exercise and develop the out-rotators of the lower extremity, *i.e.*, pyriformis, gemelli, obturators, and quadratus femoris. The result was excellent, for at

this time his feet diverge in walking and standing at about a right angle from each other, or as near that as is normal. This he was able to do perfectly within less than ten weeks after commencing the exercises.

Club-foot is often due to muscular weakness, and is generally treated with appliances, which instead of over-coming this defect too often increase it, either by doing the work of the muscles (as in the case of elastic bands), or by restraining them from action. I do not wish to be understood as saying that braces should be discarded, nor do I at all expect to see exercise altogether replace the brace, but I do hold that many cases now treated with mechanical appliances would be sooner and more permanently cured by means of proper exercise, and that those which require mechanical support would be discharged sooner from the surgeon's care if with the orthopædic apparatus there were prescribed strengthening exercises. This would vary with the kind of club-foot, and the condition of the muscles involved.

Knock-knee and bow-legs, due to feeble muscles, could also be most effectively overcome with judicious exercise. A good exercise for the treatment of knock-knee, due wholly or in part to weak muscles, would strengthen the adductors and the sartorius, gracilis, semitendinosus and semimembranosus, or inner hamstring muscles, which latter tend to adduct the leg at the knee. Besides this, there would be added growth and consequent strengthening of the internal lateral ligament of the knee from repeated tension. A good motion without the use of the pulley-weight is to stand with the knees together, and then abduct the thighs as far as possible, while the knees are flexed just enough to permit the exercise. The movement is facilitated by placing the hands on the inner side of the thighs and pressing outwards.

For bow-legs the proper motion is the opposite of that just described and brings into play the three glutei, vastus externus, rectus femoris, and tensor vaginæ femoris. Another good exercise is the reverse of that for knock-knee, and consists in standing with the feet apart and the hands upon the outer side of the thighs; the thighs are then approximated, while the knee is bent just enough to admit of the movement, and pressure is made upon the outer side of the thigh with the hands. This calls into action the adductors and in-rotators of the thigh.

Round-shoulder may be real or apparent. When apparent, it is due to a forward inclination of the head and neck; and this is best remedied by several daily exercises at retraction of the head. Better still is a head-band connected with a pulley-weight. The band is fastened to the head while facing the machine, and the weight is raised by a backward movement of the head. This is repeated with a light weight until it becomes a little difficult, at which period all further efforts must cease.

The genuine round-shoulder is treated by repeated retraction of the shoulders while the hands are clasped behind the back. Strong efforts should be made to touch the scapulæ.

The literature upon this subject is meagre or plentiful as one happens to be choice or not in the selection of what possesses real merit. As a rule, however, this work has been left to the non-medical, and hence their writings are full of errors and absurdities. All works, however, contain much information that is of value. It will be my aim in further notes to call attention in detail to the treatment of special deformities. At present it is hoped that these general indications will be of use to the general practitioner and interest the specialist.

ANTISEPTIC MIDWIFERY, AS PRACTICED IN THE PHILADELPHIA LYING-IN CHARITY.

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The principle that all infection comes from without is now generally recognized, and antiseptic measures are used in practice for the purpose of preventing infectious material gaining access to the genital passages of the parturient woman. The theory that lying-in women are at times infected by way of the respiratory passages, though supported by some eminent authorities, can hardly be considered as proved. Infection from the bowel caused by abrasion with the dirty nozzle of a syringe has been reported. This method of infection must be exceedingly uncommon. Gonorrhœa existing as a vaginitis before labor, may subsequently extend through the uterus and tubes, and set up purulent peritonitis. Likewise pus from existing pyo-salpinx (or other pus sac) may gain entrance to, and infect the peritoneum during or subsequent to labor. Instances of both these events has occurred in the practice of the Charity. But here also the infection originally came from without. Hence in the healthy parturient woman the problem is to prevent the access of noxious matter to the genital passages. In carrying out the antiseptic practice here, it is especially borne in

mind that infection is usually carried by means of the fingers, instrument or other solid bodies brought in contact with the genitalia rather than through the atmosphere.

Whether we reject the respiratory passages as a route for infection, or not, it is unquestionably a fact that a prolonged residence at a hospital except under very exceptional hygienic conditions, deteriorates the health. Hence, patients are admitted only shortly before their expected confinement. While waiting they are ordered baths, not only for cleanliness sake, but to keep the skin active. A bath is given at the beginning of labor, unless there be some contra-indication. The clothing is also changed at this time. Whenever practicable the parturient is confined in a room separate from other patients. Thus her immediate environment is aseptic.

The nurse is impressed with the principles already noticed. She is directed that not only her hands but that all instruments and implements must be made aseptic before being brought in contact with the patients genitals. The solutions used to accomplish this, *after* the use of soap and water, are bichloride of mercury solution 1–2000 where practicable, or carbolic acid 2½ to 5 per cent.—this being used more especially for instruments. Where metal catheters are re-used they are to be passed through a flame, cleansed and washed in carbolic solution. Each patient has a separate syringe, the nozzles of which are to be cleansed and disinfected after use, and again disinfected before re-use. Antiseptic gauze is used for wash-rags.

The attendant is to bear in mind that in normal labor the less the genitals are disturbed the better. Hence, information gained by abdominal palpation, both as to the position of the fœtus and the progress of labor, is doubly valuable, since it is gained without risk. Before making touch the hands are scrubbed with soap and water, nor is the nail brush spared. They are then rinsed in the bichloride solution. Carbolized oil is used as an unguent. (This is not beyond criticism.) Touch is made as seldom as possible. The placenta is expressed. This may be regarded an antiseptic measure, since it tends to prevent the retention of clots in the uterus—a favorable nidus for germs. Rents of the perinæum, unless slight, are sutured; an open avenue for infection is closed. Slight rents are touched with carbolic acid. Soiled clothing is then removed, the external genitals and surrounding parts washed with bichloride solution; a sublimate gauze napkin and the binder are now applied. The sublimate gauze napkin is dampened in the solution where it covers the vulva. In instrumental labors, where the forceps have been used in the pelvic cavity or outlet, a sublimate vaginal injection, 1–2000, is given. When the uterine cavity has been invaded by the hand or instrument, it is also irrigated, and an iodoform pencil (100 grs.) is left in the cavity. This is also done after the delivery of a macerated fœtus. Care is taken that sublimate solution is not retained either within the uterus or vagina. The amount of iodoform seems large, but poisoning has not been observed. The formula for the pencil is:

℞	Iodiformi,	ʒ v
	Acaciæ,	
	Amyli,	
	Glycerini,	āā ʒ ss
	M. ft. bacilli, No.,	iij

The pencil dissolves slowly, and thus the genital passage is bathed in iodoform for about three days.

The after-treatment is based upon the principle that the puerperal state and puerperal processes are physiological. The vagina and uterine cavity are let rigidly alone, unless special indications arise. Sutures are usually removed on the eighth day. The patient's genitalia are bathed four times daily with the sublimate solution, and the gauze napkin changed when soiled.

The gauze is made in the institution by boiling cheese cloth in a carbonate of sodium solution to remove the oil, and, after drying, soaking it in the sublimute solution, and again drying.

This method of antisepsis has the double advantage of securing for the puerpera that repose which is so necessary for her well-being, and of protecting her against the risks of sepsis. At the same time, she is not subjected to the danger of sublimate and carbolic poisoning, from which she can never be entirely free when these agents are frequently used within the genital passages.

—The *Lancet*, Feb. 25, 1888, states that a medical missionary nearly lost his life through an outburst of fanaticism at Foochow, China. It seems that the doctor, who was attending a patient with hemorrhage, immediately proceeded to check the latter in disregard of a native superstition according to which delay should have been made until the patient's friends had finished consulting the gods in the joss-house. The patient died, and the Chinese would have boiled the doctor in oil but for the courage of some of the converts.

ASCLEPIAS SYRIACA (MILKWEED) FOR LUMBAGO.

BY B. F. RECORDS, M.D.,
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Dr. Clarence G. Hollister, in the REPORTER Feb. 18, 1888, gives an excellent article on this common and inconvenient affection. As to its pathology I have no comments to make. I have observed that it is more frequent in winter and spring than at other seasons, and in wet, damp cloudy weather than during dry, cold or bracing weather. It seems to be a result frequently of "catching cold." I have further noticed that there is tonic spasm of the lumbar muscles. A few years ago I was enabled to detect a malingerer who was anxious to have his trial for attempted murder postponed, claiming that he was suffering with lumbago to such an extent that he could not leave his bed. By order of the Court I examined him and found the lumbar muscles relaxed, and deolared him a malingerer, and in four hours after having been carried into the court-house, he walked off as vigorously as an athlete, and succeeded in making his escape. I have never used the combination of remedies mentioned by Dr. Hollister; though I believe it to be good, perhaps specific; yet I have a remedy that never failed me since I began using it in 1873, and that is a decoction of *Asclepias Syriaca*, or "silkweed," "milkweed," as it is called. It is indigenous in Western Missouri, and very generally, I believe, in the Middle and Western States. It grows on rich land, in fence-corners, meadows and cleared lands not used as pastures. It is perennial; grows rapidly from early spring until August, when it is from three to six feet high. It has a purple stock as thick as a leadpencil or even the size of an index finger. It has thick fleshy leaves, very brittle, and exuding a thick, gummy, milky juice; it generally has many branches at top; blooms in August; flowers in bunches, and is purple in color; bears a rough pod as long as a finger, and from half an inch to an inch in diameter at base, tapering to a point thorn-shaped, filled with a white, fibrous, silky furze, in which are the seeds. The root grows perpendicularly, a foot to eighteen inches in length, almost without rootlets, is white and tough; the root is the part used, and may be dug any time from August until April. Its physiological action seems to be diuretic, and mildly laxative. It increases digestion, and stimulates the appetite. That is as far as I have observed its action. I believe it is to some extent a heart tonic, though of that I am not positive as yet.

In 1873, I had a severe lumbago, for which I had tried various remedies, both internal and local, including electricity; but without relief. An old farmer said he could cure me, and related his own experience, and furnished the roots. I began using a decoction, drinking a half teacupful four or five times daily, and in a few days was completely relieved. Then I recommended it to all my patrons who called for treatment, and heard from them the most extravagant praises of its virtures, in return for my suggestions. Amongst my first cases was a man about fifty-eight years old, a painter, who had been disabled from work for nearly a month. He said that when he attempted to arise of mornings that he had to roll out of bed on to the floor, and hold to the bed-post with one hand, while attempting to pull on his pantaloons with the other. He could not stand still, but had to keep moving constantly until he could get to a seat. I gave him some of the roots, and he used the tea through the day and next morning, got out of bed and dressed with but little pain, and in a week was able to resume his trade. Since then I have met and treated perhaps a hundred cases with like results.

In 1875 or 1876, I saw an article in the MEDICAL AND SURGICAL REPORTER, from some physician in New York (his name and location I have forgotten), stating the action of *asclepias syriaca* in dropsy. At that time I had a typical case of general anasarca, in a man sixty-five years old. He had heart disease badly. His case grew from bad to worse, baffling me with the best remedies I could find. The anasarca had extended up to the thorax. He could not lie down. His body and limbs were distended until the skin seemed ready to burst. I regarded his case hopeless; but concluded to give the silkweed a trial. I punctured his limbs in numerous places and wrapped them in cloths, and thus started a flow of the water. I put him on a free use of the tea, and in ten days he was reduced to a mere skeleton; but could lie down and sleep comfortably. His appetite returned; his bowels from being torpid, acted normally, and there was a constant healthy action of the kidneys. His heart's action became more regular and its impulse strong. He lived a year and a half happy and content, when his heart suddenly failed, and he died in a few hours. I have used the same remedy in a few similar cases since and it has proved the *best* of all remedies so far.

Reports of Clinics.

CHARCOT ON APHASIA AND AGRAPHIA.[1]

REPORTED BY PIERRE MARIE.

In a lecture delivered at the Salpêtrière, in December, 1887, Professor Charcot showed a new case of agraphia and entered into some details of the history of this special mode of aphasia, to the study of which he has so largely contributed. I have thought it would be interesting to reproduce the principal points of the teaching of our master upon this subject. The patient was a woman, 64 years of age, presenting certain hereditary antecedents, who, in 1868, at the age of 44, had her first attack of hemiplegia. It was a right-sided hemiplegia and was accompanied by paralysis of the tongue. Normal speech, as well as movement, returned after the lapse of a certain time. But since this time there has existed a genuine impossibility to write, although the patient was perfectly able to hold the pen, knew what she wished to write, and had even preserved the accurate visual conception of the orthography of the words; but the idea of the letters was not present, she could no longer remember what form to give the letters. It was, moreover, certain that, prior to this time, she had possessed a considerable degree of education, which was proved by the examination of her expense book kept up to the date of her illness. It was also shown that, since the hemiplegic attack, the patient had read the newspaper daily and spoken distinctly. In 1879 there was a second attack, the woman falling suddenly in the street, stricken with left hemiplegia and complete loss of language. Since this time there has been a paresis of the right side, but language returned at the end of two years. In 1885 there was a third attack, followed by a certain difficulty of speech, characterized as a transitory trouble of articulation. Lastly, during the same year there was a fourth attack, resulting in complete and permanent loss of speech. Since then there has been a pseudo-bulbar labio-glosso-pharyngo-laryngeal paralysis, so extreme that sometimes it has been necessary, so difficult was deglutition, to nourish the patient by means of œsophageal tube. The laryngoscope clearly shows that the cartilages of the glottis cannot be sufficiently approximated to produce sound. But this is a phenomenon added to and wholly independent of the agraphia which has existed alone since 1868. Besides this, as is easily seen, the patient is neither deaf, nor verbally blind; she sketches, without hesitation, the objects of which the names are written or spoken. The inability to write does not proceed from paresis of the hands, which is not so great as to prevent her from holding a pen and copying fairly well the characters and figures printed or written before her. But when she wishes to "compose," to write what is dictated by her own thought or what is communicated to her, that is entirely a different affair, and she is absolutely incapable of doing it. In a word, this patient has preserved the visual image, the auditory image, and perhaps also the motor image of articulation, though of this last faculty one is unable to judge, because of the laryngeal paralysis. But she has completely lost the mechanism intermediating the translation of thought into written language. It is, therefore, a case of true agraphia.

According to the definition of Professor Charcot, agraphia is the more or less complete loss of coördinate movements communicated to the hand to express thought by writing, or more simply still, it may be called aphasia of the hand. This loss of coördinate movements is, moreover, independent of any other paralysis or paresis of movements, as may be proved by giving the patients characters or figures to copy, or having them execute such delicate work as sewing, crocheting, etc.

The word agraphia was introduced into scientific vocabulary in 1867 by the physiologist Ogle. The affection itself had already been exactly described by Marcé before the Biological Society, in 1856, who described the symptom of agraphia and sought to establish its independence. But this independence was not clearly and fully demonstrated until lately, and is due to the double series of proofs furnished by Charcot in 1883 and subsequent years. He first showed a case in which agraphia existed entirely disconnected from all other forms of aphasia, and, secondly, he proved that, in certain cases, the graphic faculty persisted, while other forms of language were wanting, and that in these cases the former may to a certain degree supplement the latter. It being thus shown that the faculty of written language may separately disappear or be preserved, its independent existence can no longer be doubted.

We thus clinically arrive at the isolation of four elements of speech: The auditory image, the visual image, the motor image of articulation, and the motor image of the

[1] Translated for the Reporter, from the *Progrès Médical.*

written word. In this connection M. Charcot noticed an interesting passage in the works of an English physician, Hartley (Observations on Man, 1749), a precursor of the great English physiological school of to-day, in which this physician by the simple methods of abstract reasoning reached the following conclusions:

"Words may be considered under four aspects: 1, as impressions made upon the ear; 2, as acts of the organ of speech; 3, as impressions made upon the eye by the written or printed character; 4, as acts of the hand in writing. Upon reflection we shall find that all the ideas excited by the word proceed from one of the four sources we have mentioned, especially from the first, or auditory element, and the third or visual element."

We thus see that in ascribing a preponderating importance to these two sources of the idea of the word, Hartley did not exclude the others. Such is the basis of the opinions of M. Charcot regarding the function of language, the multiplicity and relative independence of the sources whence we draw the elements of the word.

We thus find that the substance of the faculty of language may be resolved into four special modes of the memory of the word (or the impressions and acts by which we enter into relation with the same): suppress either of these partial memories and you produce one, and sometimes even several kinds of aphasia. According to the teaching of Professor Charcot, aphasia is only an amnesia; and, on the other hand, every verbal amnesia, however slight or limited, is an aphasia. Accordingly there will remain to be considered along with the corresponding aphasias, which represent the highest degree, also the auditory amnesias, the visual motor of articulation and the graphic motor, which represent a lower degree. Upon this point Charcot has always especially insisted, since, according to his belief, amnesia is the key of all the questions of the affections of language which we are studying.

This idea of memories and of partial amnesias having for its basis an independence of centres, is, as one may easily understand, the direct counterpart of the theory that seeks to establish an absolute supremacy of the sensory over the motor centres, and that the latter act only by a sort of reflex proceeding from the first. This theory is almost entirely rejected by Professor Charcot as being entirely too absolute. The notion of amnesia applied to each of these centres in particular, is, in fact, the counterpart of this theory, since it is based upon the independence of these centres among each other. Clinical facts, moreover, furnish us unanswerable arguments. Cases have often been found the most pronounced where verbal blindness was unaccompanied by any degree of agraphia; to such a degree, indeed (as Charcot has shown in several patients attacked with word-blindness), that in tracing characters with the hand, they come at last to understand the meaning of what they write. Likewise as regards verbal deafness, it is not rare to find it existing alone without aphemia. Several cases of this kind have been published, that of Hitzig being a beautiful example. We have here an evident proof that the motor centre of articulation has a distinct existence, and may be called into action without any reflex act from the auditory verbal centre.

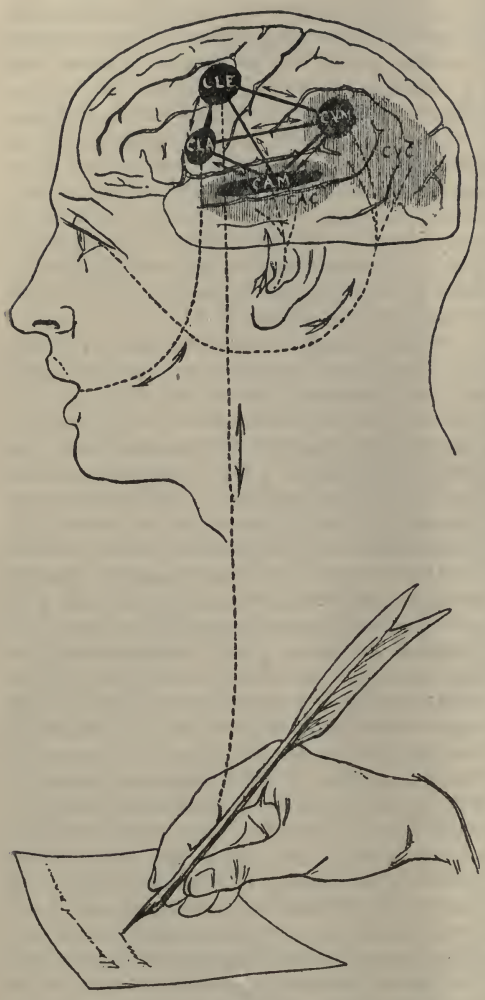
By the accompanying figure we may easily gain a notion of the centres of partial memory, the connections uniting them one to another, and of their relations with the external world. Let us take, for example, the centre for the memory of written language, or the visual centre of words, C V M; it is through the eye that the special ideas having the characteristics of the written word come to it, at the same time that the more general notions which concern, not the signification of the characters but simply their form, their external appearance, are being gathered in the common visual centre, C V C. If the visual centre for words be injured, the patient is still able to see the written words but does not comprehend them, he has verbal blindness. But if the lesion is not localized exactly at this point, which is generally the case, there is another phenomenon added: the patient will no longer perceive with this part of the brain, by the common visual centre for general visual impressions of objects—he will at the same time be attacked with both verbal blindness and with pschical blindness, the last appearing clinically under the form of hemianopsia.

The same may be said of the auditory centres, C A C, C A M.

As to the motor centres, whether of articulation or of writing, similar observations may be made, but with noteworthy differences. Just as we have seen the visual centre of words to be in intimate relation with the common visual centre, so the motor centre of written language, C L E, is in relation with the common motor centre of the superior member, and the motor centre of articulation, C L A, is in close connection

with the common motor centre of the tongue and lips. In order not to complicate the figure these two common motor centres have not been drawn, it being only necessary to mention this analogy.

It will be noticed that in the illustration the visual and auditory centres are related to



C V C—Common visual center.—C V M Visual center of words.

C A C—Common auditory center.—C A M Auditory center of words.

C L A—Motor center of articulate language.—C L E—Motor center of written language.

(The location of the centers is simply schematic and has no pretension to topographic or anatomical accuracy.)

the external world only by a single centripetal line. They are in reality only centres of impression. The motor centres of articulation and of writing are joined to the external world by a double line (or arrow): the one centrifugal, the other centripetal; that is to say, that while they are especially centres of expression, they are also, to a certain extent, centres of impression.

As to the lines uniting the four centres of the memory of words each to the other, they express the intimate and multiple connections existing between these different centres, and concerning the importance of which we shall speak later.

At present we wish to draw especial attention to the multiplicity and relative independence of the sources that furnish us with the elements of the word. Upon this notion, in reality, is founded the doctrine of functional supplementation put forth by M. Charcot in 1883, which is being more and more accepted. It is upon this conception that the method of re-education which has often produced such remarkable results, is based. A patient like Fraenkel's, attacked with verbal deafness, and not understanding the sense of spoken words, instinctively learns to reach their meaning by one of the following methods: he either repeats, articulates the words, and, by means of the movements, is finally able to understand them—in which case the motor centre presiding over the articulation of words comes to the aid of the auditory centre; or, again, the patient writes the words which he hears and in this way seizes their sense—in which case the motor graphic centre supplements the auditory centre. Frequently, also, as has been shown by several examples, the word-blind patient comes to understand the written words by retracing the characters either with the pen or with the finger in the air, in which case the graphic motor centre aids the visual centre. The stronger impressions furnished by the graphic motor centre are thus seen to re-inforce the weak impressions, and those of a doubtful character supplied by the visual impressions. We may thus see the visual centre supplied by the graphic centre, and the auditory centre by the motor centre of articulation; and this is because the memory of the movements of articulation, and the memory of graphic movements, in the same manner as visual and auditory images, form a part of interior language, and may either of them awaken the idea of the word.

But the law of the independence of centres is not an absolutely general law, since there are cases in which the suppression of sensory visual, and auditory centres, paralyzes the centre of articulation and produces motor aphasia or agraphia. According to M. Charcot the reason of these varieties is be-

cause the apparatus of language does not develop alike in all individuals. There exists in this respect very different aptitudes and types. These depend upon whether, in the interior language, this or that centre is predominant in the representation of the word, whether in this or that individual the formation of the idea of the word takes place preferably by one of the mechanisms set forth above; in which case we have to deal preeminently with a visual mechanism, an auditory, a graphic motor, a motor of articulation, or with either indifferently in the case of those who reach the representation of the word by either of the four methods in question. This idea of the different types of interior language was introduced into science by M. Charcot, and we insist upon it here because of its extreme importance. Without this it is impossible to clearly understand the faculty of language or the different varieties of aphasia. It should be clearly understood that these distinctions are not the classifications of a sterile scientific eclecticism, but are the exact expression of the living reality.

It is indeed sufficiently clear that among the physiologists and psychologists who have most carefully studied this question of the sources of interior language, and who have shown the most penetration in their investigations upon themselves, some are exceptional in auditory development, while in others the visual or the motor centres are pre-eminent. It is thus easy to understand, as M. G. Ballet has shown in his thesis, why their results differ so much, although in each particular case the author was wholly in the right.[1]

This conception of individual varieties also enables us to understand that among the indifferents, as they are called by Charcot, those whose centres enjoy the greatest autonomy, in the case of the destruction of one of these centres, there follows more easily the phenomena of substitution by the other centres. On the other hand, those who have cultivated only a single order of the memory of verbal images, find themselves entirely at a loss if the centre of that memory is interfered with. In such cases, for example, one may see a single lesion of the auditory centre lead also to a verbal deafness, or true motor aphasia, although the convolution of Broca may be the seat of no lesion whatever; or a limited lesion of the visual centre may produce agraphia without any lesion in the centre of Exner (base of the second left frontal).

We may thus see that all those cases which *a priori* might be considered as against the theory of the independence of the faculty of written language, are in reality explained in the most natural manner, and that agraphia, as M. Charcot has shown, none the less remains a form of a perfectly autonomous aphasia.

[1] One may, for example, say that in M. Stricker the motor centres are especially developed.

It is easy to understand in view of such extensive physiological variations how difficult it becomes to trace the characters that may be clinically distinguished in cortical aphasia (lesion of the centres themselves) as distinct from aphasias of conduction or subcortical aphasias (lesion of the fibres proceeding from these centres). It does not appear that up to the present time this subject has been studied with any accurate or practical result.

Special Correspondence.

CINCINNATI LETTER.

A most humiliating affair, not only to one of our most prominent medical men, but also to the profession of the city at large, has occurred recently. A doctor's wife was stricken with cancer. The growth was removed, and she was free from it for a number of months. The disease returned with marvellous activity. Everything that could be done was done by the best of the profession of this city and the East, but she went steadily and rapidly to the end. Every one else had given her up. A wife of only four years and the mother of three children, life was dear to her. The Faith cure was urged upon her, but her husband, of course, refused. Her friends and relatives began to talk, and it was whispered about that because she was married to a doctor she could not avail herself of all methods of cure, and must die for want of freedom in her selection. Under this fire what was left for the husband but to give up. Under his protest she went to the Faith doctors, and every day they told her she was getting better, while she was really growing steadily worse. Their encouragement possibly did her some good, but she died all the same, and let herself as well as her husband out of misery. This has been a most unfortunate occurrence, for the simple fact of the wife of a prominent physician going to these quacks, even though unassisted, will be a very great thing for them to talk about. Probably they would have cured her had they "seen her earlier," or perhaps "she had not enough faith."

This story reminds me of another quack in our midst—an old "Dutch woman," a so-called "Wasser Doctorin," who has proba-

bly the largest practice in the city, and who tells bold falsehoods fearlessly about the most prominent medical men in the city consulting her and offering fabulous sums for her cures.

An effort which commends itself to the very great majority of the profession of this city is being made to bring our two general medical societies together again. About fifteen years ago there was a quarrel and a split in the Cincinnati Academy of Medicine, and some of the disaffected members resigned and started what is known as the Cincinnati Medical Society. Since that time there have been two medical societies here—a very unnecessary and unfortunate condition of affairs. Though the Academy was much the larger, having three times as many members as the other, yet it was not representative of the whole medical profession of the city. In the fifteen years which have passed, some of the men who took part in the old quarrel have taken *le grand voyage;* others have found more important things to occupy their minds, and a class of younger men has grown up who know little of this old grudge and care less. These men, when the yeas and nays are called, control both societies. They are in favor of a combination, and it is to be hoped that they will succeed in effecting one. Negotiations are already in progress to this end.

The coming meeting of the American Medical Association in this city, May 8 to 11, promises to be one of much interest. Cincinnati is accessible for the East and the West, the North and the South, and a large turn-out is confidently expected. The local profession is working very harmoniously, and arrangements for the social and scientific entertainment of our visitors are progressing nicely. The Chairman of the Committee of Arrangements is Dr. W. W. Dawson, Third and Broadway.

At the recent annual election of officers for the Cincinnati Academy of Medicine, the following was the result: *President*, Dr. C. D. Palmer; *First Vice-President*, Dr. Wm. Judkins; *Second Vice-President*, Dr. J. C. Oliver; *Secretary*, Dr. G. A. Fackler; *Treasurer*, Dr. Geo. E. Jones.

The last month has been a busy one in the medical college circles of our city. Commencements, alumni meetings and banquets have engrossed the professional attention. Many hearts have been made happy by the winning of the coveted prize, and many others are equally joyful at getting the wished-for sheepskin. A few have been called to the green-room, and some, failing to pass this second ordeal, have gone home in disgrace.

The Cincinnati College Commencement was the first, with 12 graduates and an able address delivered by Dr. L. C. Carr, Professor of Obstetrics in that instituton. The exercises were held in College Hall.

The Commencement exercises of the Ohio College of Dental Surgery were held at College Hall on the evening of March 7. Prof. H. A. Smith, Dean of the Faculty, presided; the diplomas were conferred and an address made by Geo. W. Keely, D.D.S., of Oxford, Ohio, President of the Board of Trustees. Prizes were awarded by Prof. Smith, an address made by Rev. Dudley Rhodes, and the class oration by A. B. Fletcher. The prizes were distributed as follows: Gold medal for best general examination, to H. T. Smith, of Cincinnati; second prize for best operative work, a gold medal, to J. F. Hussey, Ohio; third prize, a gold medal, for best mechanical dentistry, to W. W. Wallace, Ohio; fourth prize, a free ticket to session, for best examination in the junior department, to R. R. Bronston, of Indiana. The graduates of the Dental College were 46 in number. After the exercises a banquet was enjoyed at the Burnet House.

The exercises of the Miami College Commencement took place at the Odeon the evening of March 10. Rev. Dr. E. D. Morris, of Lane Seminary, made the opening prayer, and Prof. W. H. Taylor, Dean of the Faculty, followed with an address, reviewing the work of the college for the past year.

Mr. A. H. McGuffey addressed the graduates and delivered the diplomas. He advised the class to hold fast to the dignity of the profession of which they were this night made members; to ever hold in reverence their *alma mater* and the gentlemen who had taught them there with such patience and thoroughness. The prize of Prof. Daniel Millikin, a handsome microscope for the best examination in chemistry, was awarded Mr. H. S. McVey, a junior; Prof. Langdon's prize, a case of surgical instruments, was given to Benjamin Neal for the best anatomical examination. The William's prize, for the best examination in ophthalmology, to E. R. Axtel. The faculty prize, one hundred dollars, was awarded L. S. Elrod. The valedictory address, on the part of the faculty, was delivered by Dr. E. S. Walker, Professor of Surgery, who took as his subject, "The Malingerer." He startled his audience in the beginning by telling them that there was probably not one among them who had not at some time or other been a malingerer, to

avoid the performance of some undesired task. He then went on to state the people who were most likely to be malingerers, the diseases most likely to be simulated, and those who made up the class of malingerers. The greatest number were soldiers or sailors, who wished to escape duty or danger; yet it was found among all classes and conditions, even among children. It called for the most careful judgment on the part of the physician or surgeon; for it was certainly better that twenty guilty men should escape than that one man who was really ill should be condemned as a malingerer. The speaker reported a number of cases, and gave some unique ways in which disease and injury had been feigned. He said it was often the case in hospitals that patients would wish to remain after they were entirely recovered, and would feign all sorts of imaginary ailments to attain this end. A mixture which usually fixed them up in a hurry was the "mistura diabolica." It is composed of asafetida, aloes, and valerian, and is a terrible compound.

Closing his remarks on malingering, the speaker then turned to the graduating class and gave them some good advice. As a good code of ethics, he recommended the golden rule, and he told his hearers not to be jealous overmuch of their neighbor's success and to mind their own affairs, with much other good counsel. After the commencement exercises the faculty entertained the graduating class, the alumni and the staff of the Cincinnati Hospital, at a sumptuous banquet at the Burnet House.

The following officers were chosen at the alumni meeting: *President*, Dr. Chapman; *First Vice-President*, Dr. F. W. Langdon; *Second Vice-President*, Dr. Collins; *Secretary*, Dr. J. C. Oliver; *Treasurer*, Dr. B. Merrill Ricketts; *Executive Committee*, Drs. Stanton, J. A. Thompson and G. R. Holmes.

The commencement of the Medical College of Ohio occurred at the Odeon, on the evening of March 8, 1888. It was the 69th annual commencement of this well-known college, and the spacious hall was crowded to its utmost capacity with the friends of the institution. The trustees of the college, the faculty and alumni occupied seats on the stage and formed a brilliant assemblage. Rev. W. H. Warren, pastor of the Vine St. Congregational church, opened the exercises of the evening with prayer. Prof. W. W. Seeley, Dean of the College then made a few remarks stating the work of the year, and referred to the loss of three of the candidates by death from typhoid fever. Several others were sick so long a time from this disease that they were deterred from coming up for examination. One of those who died was Dr. Anderson Rawlston, who would have graduated last year but remained over a year as interne in the Cincinnati Hospital. Here in the faithful discharge of duty he contracted typhoid fever, and after a long and terrible struggle gave up his life. By his geniality he had made for himself a host of friends while studying here.

Hon. W. W. Dickson, president of the Board of Trustees, with the usual assistance from Dr. Conner, delivered the diplomas to the happy graduates who numbered seventy in all. Mr. Dickson then made an address to the class of which the following is an abstract:

That you have chosen medicine for your profession, indicates that your aim is not simple money-getting. No doubt if you are reasonably successful you will make a living by your chosen life work, but were it your ambition to become a plutocrat you would scarcely have selected medicine as your route to riches. Yet money has its uses. A reasonable amount of it means good food, good clothing and shelter. More of it and we have the luxuries, a fine house, rich raiment and dainty food. And then with plutocratic wealth you may play polo, ride behind a $50,000 horse, sail the seas in costly yachts, cover your wife with resplendent clothing and diamonds, or she may follow a pug dog costing thousands. Money is an excellent servant but an ignoble and remorseless master. Young gentlemen, if you go from this hall determined to keep the better sentiments uppermost, if you reserve your homage for moral and mental worth, you may accomplish much. But we speak louder by deeds than words. So bear yourself in your profession that it will command respect.

The following prizes were then distributed: Prof. Whittaker's prize, a case of instruments of precision, for the best examination in theory and practice, given to Dr. Theodore Mumaugh, Lima, O.; Prof. C. D. Palmer's prize in obstetrics and gynæcology, case of instruments, for the best examination in this department, to Dr. John Edwin Wilson, Falmouth, Ky.; Prof. P. S. Conner's prize in surgery, a case of surgical instruments, to Dr. W. Edgar Hover, Lima, Ohio; Prof. W. W. Dawson's prize for best bandaging, to Dr. George A. Welch, Athens, Ohio; Prof. Dawson's prize, for best dissection, a gold medal, to Dr. Homer C. Bennett, of Bellefontaine, Ohio; Prof. Thad. A. Reamy's prize in clinical gynæcology, a gold medal, to Dr. Ed. W. Johnston, Union City, Ind.;

Drs. DeBeck and A. V. Phelps of the histological laboratory gave a prize, a cabinet of specimens, to Dr. Albert H. Freyberg, of Cincinnati, for the best examination in this branch; the Faculty prize, for the best examination in all branches, was given Dr. John B. Murphy, of Cincinnati; appointment as Resident Physicians to the Cincinnati Hospital, Drs. Thos. Hayes, S. F. Kramer and David Wolfstein, of Cincinnati; as Resident Physicians to the Good Samaritan Hospital, Drs. Otto Juettner, Cincinnati, and U. D. McDowell, Millersburg, Ohio; as Resident Physician to the Children's Hospital, Dr. George W. Davis, Batavia, Ohio; as Acting Assistant Surgeons to the National Military Home at Dayton, Ohio, Drs. Geo. H. Welch, Athens, Ohio, and Clarence M. Parkes, Sullivan, Ind.

Surgeon-General John A. Billings of the United States Army stationed at Washington, and a graduate of 1860, was then introduced, and delivered an address. He took for his subject the Medical College of Ohio before the war, and remarked that before he was through his paper he was not sure that he should not have called it The Medical College of Ohio during the war, for those days of early growth and progress were so replete with strife. He gave a most graphic description of the early days of the old College, and perfect pen pictures of some of the older members of the faculty about whom we now read. He related how it was the custom then to require of the candidate for graduation the writing of an inaugural thesis. It was the performance of this melancholy duty which led him into the line of work which has occupied the greater part of his time for the past twenty years. In the search through the public and private libraries of Cincinnati, Philadelphia, New York and elsewhere, which lasted over a period of six months, he became convinced of three things: The first was, that it requires a vast amount of time and labor to search through a thousand volumes of medical books and journals for items on a particular subject, and that the indices of such books and journals can not always be relied on for their contents. The second was, that there are in existence somewhere over 100,000 volumes of such medical books and journals, not counting re-prints. The third was, that while there was nowhere in the world a library that contained all these books there was not in the United States even a fairly good one. This it was that led him at the close of the war to try to establish for the use of physicians a fairly complete medical library at Washington, and in connection with this to prepare a comprehensive catalogue and index which would spare medical writers and teachers much drudgery. The paper was quite long, and full of interest.

The valedictory address, on the part of the Faculty, was made by Prof. C. D. Palmer. An elegant collation was served after the close of these exercises.

Periscope.

Allochiria.

At the meeting of the Biological Society of Paris, January 14, 1888, M. Gellé reported a case of auditory allochiria, and remarked that allochiria is the perception of sensation on the side of the body opposite to that which is irritated. This phenomenon has been especially observed since Obermeister's description, in patients suffering with locomotor ataxia and in affections of the cord, either traumatic or otherwise, and up to the present time, the observations have been with cutaneous sensations. The patient, feels, for example, in the right leg a blow struck upon the left leg. In Gellé's case, a noise produced at the right ear is heard only at the left. The patient is affected with Menière's vertigo, with manifest lesions of the middle ear, especially the left. Pressure upon the left ear provokes vertigo after a time, and causes pain; hearing is also painful on this side. The right ear is relatively good. The patient is not tabetic, nor paralytic, nor hysterical, and she has since recovered. The patient heard on the left side a piping sound produced in the right carotid. M. Féré stated that he had observed the same kind of phenomena in hysterical patients. Brown-Séquard thought that M. Gellé's observations tended to confirm the theory which he had maintained for a long time, that there do not exist double centres, but simple centres for the two halves of the body.—*Progrès Médical*, January 21, 1888.

Interstitial Salpingitis.

Dr. H. J. Boldt, in a paper on interstitial salpingitis in the *American Journal of Obstetrics*, February, 1888, says that the inflammatory processes occurring in the Fallopian tubes have usually been divided into catarrhal salpingitis and salpingitis. He adopts the term interstitial salpingitis from A. Martin's book, "Pathologie and Therapie der Frauenkrankheiten," because it expresses the pathological conditions present. He has not found primary tubal inflammation; for usually

the inflammation is transmitted from the uterus. Inflammation of the mucosa may be catarrhal or purulent, and varies greatly in degree. In interstitial inflammation the connective tissue between the muscle-bundles is first invaded, and the process varies from slight inflammation to partial destruction of the walls by suppuration. Boldt considers interstitial inflammation to be secondary to that of the mucosa, though in gonorrhœic and septic infection in the puerperal state the disease may run such a rapid course that both appear almost simultaneously. He considers that suppurative salpingitis is always caused by septic or gonorrhœal infection; also that it is possible for catarrhal salpingitis to be converted into the purulent form by intense irritation, as by intra-uterine injections, or incautious manual examinations.

Before subjecting patients with disease of the Fallopian tubes to operation, Boldt always treats them for a period varying from four months to one year, in order to satisfy himself that they cannot recover without operation. But for pyo-salpinx, following or accompanying the puerperal state, he advises immediate operation.

Four illustrative cases are reported in the paper referred to, and the conditions found under the microscope are described and figured. The first stage of the process is given as an œdema of the interstitial tissue; the next is marked by an infiltration with inflammatory corpuscles, with a simultaneous breaking up of the smooth muscle-fibre into such corpuscles, which are also derived in part from the connective tissue. The inflammation varies much in intensity, and may result in more or less breaking down of the tissue in the formation of miliary abscesses, or in diffuse purulent infiltration. Interstitial salpingitis is considered the initial form of both miliary and diffuse tuberculosis. Besides abscess and purulent infiltration, hyperplasia and atrophy are described as terminations of the process. Boldt thinks that in atrophy of the Fallopian tube a number of the epithelia and muscle-fibres perish by being converted into medullary or inflammatory corpuscles. Atresia of the tube is explained upon this hypothesis, or else that the epithelia have been destroyed by ulceration. In all cases of interstitial salpingitis described by Boldt, more or less marked peritonitis could be seen, either in the form of acute swelling or as pseudo-membranes, caused by the transportations of infectious material—micro-organism or ptomaines—to the peritoneum, by way of the connective tissue.

Treatment of Migraine with Antipyrin.

T. J. Bokenham, of St. Bartholomew's Hospital, in a communication to the *Practitioner*, February, 1888, says that during the last two months he has had an opportunity of treating as many as twenty-six cases of migraine with antipyrin. The results have been in every case perfectly satisfactory, although the dose given has been quite small, in no case exceeding four grains. He describes three typical cases: namely that of a near relative; that of a girl, the members of whose family exhibited epileptic tendencies; and an attack as occurring in himself.

His own migraine is usually brought on by over-use of the eyes, and is almost invariably preceded by well-marked teichopsia, which lasts for from half an hour to several hours. As the attack proceeds, he gets a tender spot on some part of the scalp, generally in the right parietal region, a vascular disturbance, with throbbing behind the right eye. The first time he took antipyrin it was in a dose of three grains, and after the pain was well developed. In a very short time the throbbing entirely ceased, leaving only a dull aching pain behind the eye; the flushing of the face also diminished. After half an hour he took a second dose of three grains, and by the end of an hour from the time of taking the first dose he was quite well, with the exception of a slight tenderness of the scalp. Since then he has tried the drug, in the same dose, taking it as soon as the teichopsia comes on, with complete success in altogether preventing the attack.

The second case is that of a woman who had been subject to attacks of migraine for many years. The starting point of her attacks is also in the eyes. For a long time large doses of ammonium bromide were successful in cutting short the attacks, but recently this drug seems to have lost most of its power. Antipyrin entirely relieved the prostration and pain after the second dose of three grains.

The third case is interesting in that it points to another class of cases in which antipyrin may be of use, namely epilepsy. Here the mother is epileptic, the father is of a very excitable temperament, and another member of the family showed signs of weak intellect. In this case migraine usually followed any undue fatigue, and was attended with a good deal of prostration. The author says he happened to be with her during one attack and promptly administered antipyrin. The headache yielded entirely after the second dose of four grains. He has also under observation two epileptics, in whom the fits are

preceeded by a well-marked aura in the shape of tingling of the extremities of the fingers. They are directed to take, as soon as they feel this sensation, ten grains of antipyrin in a little water. If the theory of Dr. Liveing concerning the close pathological relation between migraine and the other so-called paroxysmal neuroses be true, there is some hope that in both these diseases we may be able to check or to cut short the attack by the timely use of antipyrin. He has not yet had the opportunity of observing the effect on these two epileptics, but it would certainly seem to be worth a trial.

He feels sure that antipyrin requires only to be known to become a regular remedy in the treatment of migraine, and that practitioners will use the small dose with less hesitation than they would the large ones previously given.

Treatment of Inflammations in the Region of the Ileo-Cæcal Valve.

Dr. M. H. Richardson, surgeon to the Massachusetts General Hospital, in a paper read before the Suffolk District Medical Society (*Boston Med. and Surg. Journal*, January 26, 1888), sums up his conclusions as to the proper treatment for these cases in the following propositions:

1. In mild cases of inflammation in the region of the appendix there should be no surgical interference till physical examination reveals the presence of an abscess, which should be incised by the post-peritoneal method.

2. In violent cases, where it is evident that there is a general peritonitis, laparotomy should be done immediately, just as soon as a diagnosis of general peritonitis has been made.

3. In violent cases where it is doubtful whether the general peritoneal cavity has yet been invaded, and where the history and the physical examination favor the presence of an abscess in the ileo-cæcal region, though it is impossible to locate the exact seat of the inflammatory process, an exploratory incision should first be made in the right iliac fossa, and the ileo-cæcal region explored post-peritoneally.

4. The best incision to reach the appendix in the average case, is along the outer border of the rectus, about four and a half inches from the spine of the pubes.

5. The best incision for extra-peritoneal exploration is parallel and close to Poupart's ligament, beginning in about the centre, and extending outwards and backwards a sufficient distance.

At the same meeting Dr. J. W. Elliot reported a case of perforation of the vermiform appendix, causing an intra-peritoneal abscess and general adhesive peritonitis, and the following propositions were formulated for discussion:

1. For cases of chronic or subacute perityphlitis with a small tumor, or without tumor, expectant treatment.

2. For cases of chronic or subacute perityphlitis with a large and increasing tumor, extra-peritoneal incision.

3. For cases of acute perityphlitis with threatening symptoms and with tumor, extra-peritoneal incision.

4. For cases of rapidly acute perityphlitis with alarming symptoms, and without appreciable tumor, exploratory incision (extra or intra-peritoneal).

Dysentery in Ireland.

At a meeting of the Royal Academy of Medicine in Ireland, on January 13, 1888, Mr. Conolly Norman made a communication as to the cause of the outbreak of dysentery with which he had to deal in the Richmond Lunatic Asylum, in Dublin. Mr. Norman stated his belief that the outbreak was due to defective drainage, and laid down the following as probable general laws that regulate the appearance of dysentery: 1. Dysentery is communicated through exhalations from a soil saturated with the products of organic decomposition. 2. The incidence of dysentery at particular times and seasons is due to the increased moisture of the soil at such times. 3. When dysentery breaks out there is commonly a concurrent outbreak of severe diarrhœa. 4. Dysentery appears where dysentery has been before. 5. When dysentery appears over a large area, including its own haunt, it appears in the latter situation in its worst form and to the greatest extent. 6. Like other malarial affections, dysentery attacks by preference those who are not acclimatized to the conditions that have produced it.

Mr. Frazer believed that dysentery was and could be contagious, for he remembered making a *post-mortem* examination in the Richmond Hospital from which he got a most severe attack of dysentery, and which he believed to have been produced by contagion. He was not satisfied with Mr. Conolly Norman's observations upon malaria. From the most remote times dysentery had been epidemic in Ireland. In the battles during the reign of Elizabeth the soldiers were decimated by it; the same thing occurred during the wars of Cromwell and William III; and yet Ireland had always been remarkably free from

malaria. But that dysentery might be associated with malaria, on the other hand, was possible. Malaria, as such, was confined to very limited districts in Ireland. He knew that it existed along the Dublin river; but there had been no co-existence of dysentery in those spots. Another remarkable fact was that it occurred in certain seasons of the year. It was well-known to break out in the autumn, especially after the first frosts, which was accounted for in former times by persons drinking water containing animal and vegetable material in a state of decay. As for its mortality, he was resident in the hospital during the years of 1847, 1848, and 1849, and had to attend specially upon fever and dysentery; and the mortality in cases of dysentery—of which only the very bad were admitted—was three times as great as in the worst fever cases; it amounted at one period to one out of every four cases. Dr. Cheyne used the remarkable expression that dysentery was "fever turned in on the bowels." His preparations illustrative of the disease were in the Richmond Hospital, and were described in the series of the Dublin hospital reports. —*British Med. Journal*, February 4, 1888.

Case of Chronic Mercurialism.

At the meeting of the Society of Internal Medicine, February 6, 1888, Dr. Landgraf reported the case of a mechanic, twenty-five years old, who had previously enjoyed good health. Since May, 1887, he had been engaged in carbonizing in a factory which made the loops for Edison's incandescent lamps. The table at which he was at work stood immediately under a large tube which is filled with mercury, and has a small opening from which the mercury flows upon the table. He has often found mercury in his pockets. He admits also that in course of time his dinner kettle has become completely silvered. Notwithstanding all this, the patient was in perfectly good health, until six weeks before Christmas; in other words, after being engaged in this work for six months.

The first symptoms of intoxication were mercurial stomatitis, slight bleeding from the gums, and fetor from the mouth. These symptoms subsided under the use of suitable gargles. Soon after this, uncertainty in the use of the hand appeared. The patient noticed that he became excited; he could still perform his duties, but just as soon as anyone looked at him he became restless, and was unable to work. At last, the approach of his chief would cause him to stop at once in the midst of his work. He quit work in January, 1888, and on January 31 came in his present condition to the Charité. The patient is a strong muscular man, whose internal organs are entirely sound. The pulse is persistently slow, beating 50 or 60 times to the minute, and there is a double sound in the crural arteries. He complains now of stomatitis, slight bleeding from the gums, ulcerations, oppression in the epigastrium; he has no diarrhœa, but rather a disposition toward constipation. His chief complaint is trembling of the limbs. In spite of the strong muscular development of the arms, these tremble violently as soon as they are stretched out. This condition is more striking in the left hand than in the right, and is explained by the fact that the patient was accustomed to work with his left hand. A slight difference is also present in the lower limbs. Sensation is normal. The muscles respond more readily to the electric current than the nerves. Mercury can be detected in the urine, which is, in other respects, unaffected. The manner of the patient is most strikingly changed. In telling of his symptoms he is uncommonly talkative, but he confuses the words, putting one in place of another; this is especially true on the approach of the physician. No noteworthy change in his condition has yet occurred. — *Deutsche Medizinal-Zeitung*, Feb. 13, 1888.

Multiple Abscesses of the Liver and Lungs.

At a meeting of the Royal Academy of Medicine in Ireland, January 13, 1888, Dr. Finny exhibited specimens illustrating pyæmic multiple abscesses of the liver and lungs, which had run a rapid course of about ten days, and in which jaundice and the expectoration of pus had occurred but five days before death. The patient, who had been admitted under Dr. Finny's care into Sir Patrick Dun's Hospital on November 16, 1887, gave a history of having been treated for pain and suffering referred to the left side of the abdomen, over four years previously, and of the question being discussed as to the existence at that time of cancer of the stomach. He died on December 21, and on *post-mortem* examination, in the situation to which pain had been referred, there was found an abscess, shut in by firm and old adhesions of the peritoneum, and limited by the left kidney, the lower third of the spleen, the tail of the pancreas, and the superior surface of the splenic flexure of the colon. The abscess contained a couple of ounces of grumous, cheesy matter. The points of interest were (1) the long

duration (over four years) which had elapsed between the primary inflammation of the peritoneum and its subsequent conversion into an abscess; and, as a corollary to this, the danger, remote as well as immediate, attendant on peritoneal inflammations; (2) the mode by which the secondary abscesses of the liver and lungs were developed, namely, by the pus directly entering the portal circulation through the communication with the spleen, and thence again by the hepatic veins it was carried into the lungs; and (3) the short time which elapsed between the direct infection of the blood and the occurrence of lung abscesses, a period which may be set down as under five days; (4) the formation of the multiple abscesses was embolic in its nature, and accounted for the number and small size of the hepatic abscesses.—*British Med. Journal*, Feb. 4, 1888.

Care of the Insane.

The *Medical Record*, February 18, 1888, contains the following report of the committee of the Medical Society of the State of New York, consisting of Drs. A. Jacobi and C. R. Agnew, to which was committed that portion of the President's opening address relating to the treatment of the insane:

"1. That until comparatively recent times the insane were considered and treated as criminals and confined in dungeons or prisons. 2. Their subsequent retention in poor-houses was but a remnant and mitigation of the old system. 3. The treatment of the insane has improved with the progress of civilization. 4. Therefore special hospitals were supplied for them, and their welfare was intrusted to scientific and humane experts. 5. To return to anything like the old system of treating the insane in poor-houses or relegating them to the custody of county officials would be a grave mistake.

"As early as 1855, at a meeting of the county superintendents of the poor, held at Utica, the following, among other resolutions, was passed:

"'*Resolved*, That no insane person should be treated or in any way taken care of in any county poor or almshouse, or other receptacle provided for, and in which paupers are maintained and supported.'—Fifty-fifth Annual Report, State Asylum at Utica.

"6. For the proper classification and treatment of the insane more means are required than for the patients of general or even other special hospitals. Institutions for the insane therefore demand medical experts as superintendents, nurses trained in the general care of the sick and then in the special care of the insane; schools for the physical and intellectual training of the insane; for the practice of out-door and in-door industries, and many other appliances. 7. The Medical Society of the State of New York expresses therefore its objections to any plan or law which in any way looks to the return of the insane to the county poor-houses as being unscientific and inhumane, and expresses its conviction that those institutions, like the State Asylum, which have boards of managers accountable to the State government and also the public, are best adapted for the care of the insane poor of the State."

The report was adopted, Feb. 9, 1888.

Action of Green Hellebore Upon the Heart and Circulation.

Christovich (*Revista de ciencias médicas de Barcelona*), after testing the action of the watery extract of green hellebore root upon dogs and frogs, gave it to eleven patients who were suffering from heart disease, with disturbed compensation. From these observations he obtained the following results: 1. The contractions of the heart were more energetic, which fact could be recognized by the increased strength of the impulse. The heart sounds were louder, and the pulse waves showed increased tension. In those cases in which a difference existed between the number of contractions of the heart and the number of pulse beats, this difference disappeared or became less. 2. The frequency of the contractions of the heart diminished in those cases in which it had been excessive. 3. Irregularity in the rhythm of the heart contractions diminished in a few cases. 4. Congestive symptoms in the lungs, liver and kidneys disappeared or grew fewer. 5. The quantity of urine was increased. 6. Where dropsies existed, these were removed, and the body weight diminished in consequence.

The author found that complication of heart disease with nephritis considerably interfered with the action of the drug. In two cases an infusion of the root (25 parts to 200) was employed in tablespoonful doses every two hours; and in the remaining cases he gave from 10 to 20 drops of a solution of the extract (one part to 100), from four to six times a day. The clinical observations were conducted under Botkin.—*Deutsche Medizinal-Zeitung*, January 30, 1888.

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ERYTHROPHLŒINE, A NEW LOCAL ANÆSTHETIC.

In a communication read before the Berlin Medical Society, last January, DR. L. LEWIN reported the result of his examination into the physiological properties of the African Haya poison, obtained from the bark of the *erythrophlœum judiciale*. His results were incidentally referred to in our Vienna correspondence (REPORTER, March 3). He stated that a concentrated aqueous solution of the poison produced insensibility with some irritation of the cornea, which appeared later than the anæsthesia from cocaine, but lasted for eight or ten hours. It diminished the pulsation of the frog's heart from thirty to eight per minute, and induced paralysis of the extremities. Similar effects were produced in dogs, which also exhibited marked dyspnœa, and peculiar convulsions, affecting the eyelids, the muscles of the trunk and those of the intestines, but not the paralyzed limbs. Then decreasing sensitiveness was observed, and death occurred without convulsions. These effects were more marked when alcoholic extracts of the drug were used. In the pigeon, vomiting, diarrhœa, dyspnœa, convulsions and death were caused by aqueous and alcoholic extracts, injected subcutaneously; but administered by the beak, vomiting and diarrhœa were the only effects produced. Suspecting from the effects, from his knowledge of African poisons and from microscopic inspection of the poison, that the *erythrophlœum judiciale* was the active drug, Lewin obtained erythrophlœine hydrochlorate from Merck, and found that a two per cent. concentrated solution produced, with great irritation of the conjunctiva, contraction of the pupil and insensibility of the eye. Solutions of one-quarter per cent., or even one-tenth per cent., produced after fifteen to twenty minutes anæsthesia of the cornea, without apparent irritation. After injecting the solution of Haya poison under the skin of the Guinea-pig, Lewin was able to cut down as far as the muscles without indication of causing pain. It would seem either that an irritating principle is present which has not been separated from the erythrophlœine, but which is not effective in great dilution, or that the erythrophlœine itself is irritating in all but the weakest solutions.

The anæsthetic effects asserted by Lewin to follow from the local use of erythrophlœine have been confirmed in some degree by other observers. Thus F. GOLDSCHMIDT, in a communication to the *Centralblatt für klin. Medizin*, No. 7, 1888, states that after the instillation into the eyes of rabbits of a one-tenth of one per cent. solution, anæsthesia was produced which continued three or four hours; while if a one per cent. solution was used, the anæsthesia persisted for twenty-four hours. Nevertheless, complete insensibility did not result even from the instillation of several drops of a concentrated solution. In the healthy human eye he found that the weaker solution was sufficient to produce complete anæsthesia, which appeared in about fifteen minutes and lasted three or four hours. No bad effects were noted with the exception of slight conjunctival irritation and a corresponding feeling of burning and heat in the eye; there was no change in the pupil, nor in its reaction, nor in accommodation or sharpness of vision. He successfully employed it in the extraction of some fragments

of iron from the cornea, and in slitting up the lachrymal canal. The operations were painless. Goldschmidt, however, does not think that the drug will find extensive therapeutic application because, unlike cocaine, it dilates the vessels.

A. von Reiss, of Vienna, (*Intern. klin. Rundschau*, No. 8, 1888; *Deutsche Medizinal-Zeitung*, March 1, 1888), substantially confirms these results. Anæsthesia, in his experiments, was not as complete as that following the use of cocaine, while one or two hours after the instillation there was always cloudiness of the epithelial layer of the cornea, lachrymation, hyperæmia of the conjunctiva, and ciliary injection. Deeper lying opacities were also noted, but in twenty-four hours the eye became normal. These results followed the use of a one-quarter per cent. solution. When the solution employed was of a strength of a little over one-tenth per cent., no bad effects were noticed, and partial anæsthesia was secured. A. Königstein (*Internat. klin. Rundschau*, No. 8, 1888), also confirms in the main the result just stated, but thinks that the drug will find no employment in eye surgery.

Finally, at a meeting of the Berlin Medical Society, February 29, 1888, (*Deutsche med. Wochenschrift*, March 8, 1888), Dr. G. Gutmann reported a case in which he had instilled into the eye two drops of a two-tenths per cent. solution, for the purpose of obtaining sufficient anæsthesia to remove a foreign body from the cornea. Anæsthesia developed in half an hour, and the foreign body was removed as successfully as though cocaine had been used. But on the following day there was a very intense grayish-white cloudiness of the whole cornea, which was also quite anæsthetic. This condition continued for four or five days, and even after eight days the cornea was still anæsthetic. From the eighth to the eleventh day the cloudiness of the cornea began to diminish at the periphery. Anæsthesia was demonstrable in the centre of the cornea as late as the fourteenth day, but the cornea had cleared up so that there was only slight haziness in the centre.

Bearing in mind the rise and fall of the alleged local anæsthetics, "gleditschine" and "drumine," it behooves one to be cautious in expressing any opinion bearing upon the probable value of erythrophlœine. It is not at all unlikely that it possesses genuine anæsthetic powers, but the indications are also strong that it may prove too irritating for use upon the more sensitive mucous membranes.

LORETA'S OPERATION: DIGITAL DILATATION OF THE PYLORUS.

What is known by the brief and appropriate name of "Loreta's Operation," consists in making an opening through the wall of the abdomen, into the stomach, and then stretching the pyloric orifice with the fingers. It was first practiced by Loreta, of Bologna, in 1882, and has been done a few times since. The last case reported was done by Loreta, January 30, 1888. The patient was a man fifty-four years old, who had been very intemperate, and who had suffered with dyspepsia since 1872, and with symptoms of stricture of the pylorus since 1880. When examined he was thin, his stomach was dilated, and a hard, fibrous cord could be felt in the region of the pylorus.

In carrying out the operation, Professor Loreta first washed out the stomach with an alkaline solution and then made an incision along the linea alba from the lower end of the sternum to the umbilicus. This exposed the stomach, which was drawn partly out of the wound, and opened midway between the greater and lesser curvatures. The index finger was then passed into the stomach in the direction of the pylorus, through which it could not be pushed. A large urethral bougie and after an œsophageal sound were then passed through into the duodenum. By this means the stricture was so far dilated that the operator was able to get his finger through the pylorus and draw it over almost to the abdominal wound. The index of the left hand was then also passed through on the right as a guide. The pyloric orifice was then dilated by forcible divulsion with the two fingers, a proceeding which the tightness of the stricture rendered very difficult. Finally, the wound in the stomach was closed

by continuous, and that, in the abdominal wall by interrupted, sutures, and an antiseptic dressing was applied. On February 9, the wound was healed, and the patient was completely free from his troublesome symptoms. Digestion was perfect, vomiting had entirely ceased, and the man had lost the look of suffering which had been so marked before the operation. Dr. Bufalini, who reports the case, says that not a single instance of relapse after Loreta's operation has yet been heard of.

We call the attention of our readers to this operation because it is one which has many things to recommend it, and because it seems probable that a greater familiarity with what may be done for patients with obstructions in the course of the alimentary canal might lead to the prolongation of lives imperilled by obstructions. The contents of the abdominal cavity are now so frequently and so successfully operated upon, that there seems to be no good reason why persons suspected of having stenosis of either orifice of the stomach should be permitted to die without an attempt being made to prolong their lives by means of a surgical operation. Only recently a man, with stricture of the lowest part of the œsophagus, died in a city in Pennsylvania, who might have lived longer if his stomach had been opened and the stricture dilated. It is possible that there were reasons for this which have not yet appeared; but it is also possible that, if his medical attendants had been fully aware of what has been done for the relief of such patients, they would have added his case to the number of those in which abdominal surgery has achieved such happy results.

FLEXION OF THE UTERUS AND OBSTRUCTION.

In several recent publications certain writers have opposed the commonly accepted and time-honored view that flexion of the uterus tends to obliterate the lumen of the cervix uteri. Their argument is deserving of great respect, although it leaves unexplained the symptoms so often observed of periods of comparative rest and comfort followed by colicky pains and the expulsion of menstrual discharges, which in their turn are succeeded by periods of rest and the cessation of the menstrual flow. These symptoms are so often present in cases of flexion of the lower segment of the uterus, that the old illustration of a bent elastic tube seems to be applicable to the condition existing in the flexed womb.

This way of representing the mechanical conditions is supported by the appearances found in certain specimens of the uterus which are to be found in pathological museums; and only recently (*British Medical Journal*, March 3, 1888), Dr. Graily Hewitt, of London, has described and pictured such a specimen. This specimen is in the museum of University College, London, and shows an almost total obliteration of the lumen of the cervix in a case of rectangular anteflexion of the uterus. It may be objected to Dr. Hewitt's opinion as to the significance of this specimen, that its long stay in alcohol prevents it from being taken as an illustration of what occurs during life when the tissues of the uterus are soft and pliable. Such an objection is not without force; but within reasonable limits it would seem that the specimen does illustrate the mechanical conditions of a flexed uterus during life; and that they may still be regarded as not materially different from those of a bent elastic tube. This view may be incorrect; but it is not unreasonable, and it harmonizes—as we have said—so well with the rational signs which are features of almost every day observation, that it seems unnecessary to abandon it, until stronger arguments are adduced against it than we have yet seen.

PASTEUR AND PESTILENCE.

It is pleasant to note that the proposition of Pasteur to exterminate the rabbits of Australia by sowing among them the seeds of fowl-cholera, to which we alluded in the Reporter, March 10, 1888, is meeting with the opposition which we hoped it would meet in that country. His agents are said to be on the way to New South Wales; but news comes from that country that heavy penalties will be enforced against persons "who introduce diseased rabbits." This

may not apply exactly to those who propose to introduce disease germs among rabbits already there; but it is to be presumed that it is intended to prevent such a proceeding. We would be glad if the spirit of humanity were as strong in some scientific circles as the spirit of commercial enterprise is, and if the sufferings of the lower animals were not so wholly subordinated, as they sometimes are, to the gain, or even to the ailments, of their masters. But the rabbits of Australia may rejoice that, in this case, what threatens them is regarded as so threatening to mankind that they are likely to be spared the pestilence which Pasteur and his followers intended for them.

Book Reviews.

[Any book reviewed in these columns may be obtained, upon receipt of price, from the office of the Reporter.]

DISEASES OF MAN: DATA OF THEIR NOMENCLATURE, CLASSIFICATION AND GENESIS. By John W. S. Gouley, M.D., Surgeon to Bellevue Hospital. New York: J. H. Vail & Co., 1888. 12 mo., pp. 408. Price, $2.50.

It is by no means easy to review a book like this one by Dr. Gouley. One cannot fail to sympathize with its object, although one may despair of seeing this accomplished. Good work has been done of late in certain special fields of medical observation, and our English brethren have suggested a carefully prepared nomenclature covering the whole ground of medical experience, which might be better known than it is. For all this, there is still an unfortunate diversity in the terms in which medical men express themselves. It is no wonder then that one should be found so desirous of securing uniformity that he would even incur the risks of proposing a new and carefully prepared nomenclature. Such an one is Dr. Gouley. Well aware of the risks refered to, he has devoted four hundred pages to an attempt to root up the growth of centuries and to plant in its stead the production of his own verbal forcing-house. Some of the new plants have a strange look, and may not long survive their transplantation. But this, time will decide. The object of the author is commendable, and we bespeak for his work the sympathetic consideration of those who shall judge its fruits.

—A Brooklyn dentist has succeeded in placing a gold filling in one of the teeth of his five-year-old setter. The method of filling was the same that he employs in treating the teeth of his regular patients. The dog submitted to the drilling of the cavity, the plugging of the gold and the polishing, with little impatience, and did not even object to having her mouth filled with a rubber "dam." The cavity was on the outside and could be worked at easily.

Correspondence.

Masturbation and Onanism.

Editor Med. and Surg. Reporter:

Sir:—I notice in your last number, of the 17th inst., a question asked by your Kansas correspondent, in regard to "masturbation" and "Onanism," or, "if custom had made the two words interchangeable?" I only wonder the question has not been asked long before, which would have brought out the correct answer you have given said correspondent.

But, I would ask, why the author of the leading medical dictionary of this country should have suffered the error to re-appear in his revised new edition? For it was a great mistake; notwithstanding his medical dictionary has been considered as good authority in the medical world as Webster's unabridged dictionary in the English language.

Surely, a little research and study into ancient history would have convinced the most worthy and well-read author that "Onanism" was not "masturbation," but from Onan, of yore, who married his brother's widow, and took means, by partial, or incomplete sexual congress to prevent the consequences of marriage; and sacred history tells us, Jehovah was angry with him and slew him as he had slain his brother,—Gen. xxxviii: verses 8, 9 and 10. Therefore, all believers in sacred history cannot but be convinced that Onan's trespass upon nature was not "solitary vice," or so-called "self abuse." However, in a moral and physical sense we claim it is as *first cousin* to the latter.

I am sorry to feel obliged to assert, that in this Christian age of the 19th century, Onanism is *extensively* practiced both in and out of the church, by married men, who had stipulated before, or at marriage, that they would not have more than one or two children. In every case that has come to my knowledge for the past thirty years, the arrangement has resulted in unhappiness to *both* parties, and in several instances has led to divorce.

If a man treats his wife in that unnatural manner, even at her solicitation, unfaithfulness in one or the other is almost sure to result.

The act of "withdrawing" before ejaculation of semen takes place is also frequently the cause of *early* impotency and other physical debility on the part of the male, and in many instances causing congestion and displacement of the uterus in the female, and nervous prostration too. Also great aversion to the husband, and a desire to be in the

company of other men. In fact, I am confident that Onanism, "self abuse," and excessive sexual congress, have been the cause of as many "domestic hells," which have lead to divorce, as has strong drink.

Yours truly, ISAAC FARRAR, M.D.

Forcible Feeding of the Insane.

EDITOR MED. AND SURG. REPORTER:

Sir:—In an editorial on "Forcible Feeding of the Insane," in the REPORTER of March 10, an approval is given to Rader's opinion that this procedure is not only useless but dangerous. The expression of such views by a journal so widely circulated as the REPORTER is, I believe, to be deprecated; as I am convinced that forcible feeding of both insane and of hysterical fasters is too much neglected at present outside the doors of hospitals for the insane. If the reports of such cases in the daily press are to be relied upon, there is a singular absence of this rational treatment of the wilful fasters whose deaths are so invariably mentioned as a sequel.

For a number of years I was called upon to feed in this way from one to four patients twice daily, and in no single instance was there an untoward result. I do not remember one case that was not rapidly benefitted, both mentally and physically, by it. Of course the violent struggles of new cases (and sometimes of old ones) made it very difficult to pass the œsophageal tube at times, but an occasional slipping of the tube into the larynx was not productive of injury; for real force should never be used, and the sensation imparted by the larynx is readily detected. The use of force to keep an unwilling patient in the proper position on a mattress placed on the floor, should, however, be abundant; as the more force of this kind that is displayed, the less will be really used.

There is one point that deserves correction, and that is the use of the stomach-pump for this purpose. This instrument is too rigid to communicate intelligible sensations to the hand of the operator, and it is impossible while using it to tell whether the stomach is full or not. A rubber hand-ball arrangement is far better; and the best instrument for this purpose is one constructed after the principle of Hall's syringe, in which the motive power is compressed air, and in which there are no valves to be clogged and become septic.

There is no reason for any physician shrinking from a manifest duty to such patients under his charge, as the necessary instruments for the temporary feeding of the case are always at hand. A large flexible male catheter and an ordinary rubber syringe, which may be readily connected by appropriate tubing, answer all purposes until a more suitable apparatus can be obtained. To force the jaws wide enough for a gag, a blunt wooden wedge and patience are often required.

Yours very truly,

G. BETTON MASSEY, M.D.

1706 Walnut street, Philadelphia.

March 20, 1888.

NOTES AND COMMENTS.

England and Quarantine.

The editor of the *Sanitarian*, February, 1888, brings the following severe accusation against the English in their relation to what is called quarantine. They bring, he says, cholera from India to the ports of the Red Sea under cover of a clean bill of health, and distribute it at the seaports on the route. If it be overland, they leave the sick, the dying and the dead to spread the disease round about. They convey it to China and Japan, and, pushing the freedom of commerce against all restrictions, risk its introduction at every port on the Mediterranean into which they can force an entrance. But they are careful not to land it in England.

For, most remarkable of all, while the English denounce all quarantine regulations if maintained in Italy, in France, or in Spain, they enforce the most rigid quarantines at their own ports of any people in the world, even to the extent of entire exclusion, as we have before taken occasion to point out. Yet, so accommodating is England, in this respect, that while she prohibits the entry of infected ships and cargoes at her own ports, she gives them new clearances, with clean bills of health to foreign ports! And when the filthy ships and cargoes thus *forwarded* by English practice arrive at, and infect the seaports of other countries, English preaching is never wanting to make it appear that all the blame rests upon the filthy localities and habits of the people to whom she has sent her infected ships and cargoes. * * * * * Sanitarians who are alive to English practice, as against Englishmen's preaching, with regard to quarantine, will not be misled by the formulated resolutions which are the common stock-in-trade of English delegates at sanitary conferences, or the balderdash of her multitude of assayists for the promotion of commerce in disease. They will look at England's practice at home; be careful to obtain and study the reports of her port sanitary authorities, and learn with wha

care she excludes infectious ships, merchandise and diseases from her own doors; her continuous watchfulness and reports with regard to cholera, especially, at foreign ports; the names and dates of all vessels sailing from such ports, and whence; and her admirable precautions against the introduction of cholera. By thus doing they will acquire knowledge of practical sanitation to which the word "quarantine" is in no respect an index. Indeed, this word should be dropped from the vocabulary of sanitarians everywhere; it is opposed to *practical work* for the prevention of disease, and the time necessary for its exercise and to cover the incubation period of infectious diseases is all the detention that accomplished sanitarians now require anywhere.

Professional Secrets—The Michigan Law Respecting Them.

In the reports of the Michigan Supreme Court for June, 1882, we find the following in a decision written by Judge Cooley:

"A physician was called to the stand, who testified that he treated a young German lady at Benham's hotel in the city of Corunna, in December, 1879, and January, 1880," for a bad case of gonorrhœa, and that he was informed that she had been at work for Riley Storrs. This evidence ought not to be passed over for many reasons. One is that the physician had no business to give it. The statute —Comp. L. 7576—provides that 'No person duly authorized to practice physic and surgery shall be allowed to disclose any information which he may have acquired in attending any patient in his professional character, and which information was necessary to enable him to prescribe for such patient as a physician, or do any act for him as a surgeon.' Every reputable physician must know of the existence of this statute; he must know from its very terms as well as from the obvious reasons underlying it, that it is not at his option to disclose professional secrets. A rule is prescribed which he is not to be "allowed" to violate; a privilege is guarded which does not belong to him, but to his patient, and which continues indefinitely, and can be waved by no one but the patient himself." (Numerous authorities for these statements are cited and the judge goes on to say): "What was done in this case may have been thoughtlessly done; but if a physician is found disposed to violate both the law of the land and the precepts of professional ethics by making such a disclosure, and if counsel invite him to do so by their questions, the commissioner, in the case of so plain a disregard of the law to the prejudice of a third party, may well decline to be an instrument of the wrong."

Such then is the law of Michigan respecting the secrets that come to his knowledge while rendering professional service to any person. They are his only for the benefit of the interested patient. The law specifically forbids his divulging them. This is based upon common sense and the rights of all the interested parties.

We trust that this may come to the knowledge of every physician and that each one may with greater vigilance than formerly observe the law, the morals, and the good sense. We know of instances in which through ignorance of this law, physicians have submitted to brow-beating lawyers and given evidence in opposition to this law.—*American Lancet*, March, 1888.

Formulæ for Iodoform.

Dr. Howard, in *Journal de Médecine de Paris*, gives a list of useful formulæ for iodoform, from which we quote the following:

For syphilitic sores:

Iodoform	℥iij ¼
Thymol	℥viss
White sugar	gr. xvss

This powder should be well mixed and ground up. At first it should be dusted over the sore two or three times daily. Later (in four or five days) one application daily will be sufficient.

For herpes, a mixture of

Iodoform	ʒ j
Oil of eucalyptus	f ʒ iv

should be applied two or three times daily.

In granular inflammation of the eyes the author has used the following formula with great success. The powder should be dusted into the eye by means of a camel's-hair brush:

Iodoformi	gr. xvss
Sacch. lact.	ʒ iss

M. ft pulv.

Chancres, orchitis, etc., may be dressed with the following salve:

℞	Iodoformi	ʒ j
	Balsam. Peruv.	ʒ ij
	Vaselin. flav.	℥ iss
	Ol. menth. pip.	gtt. viij

M. ft. ung.

The following salve will be found of great value in burns:

Iodoformi	ʒ j
Ext. conii	ʒ iss
Acid. carbol	gr. viij
Unguent. rosat	℥ j

—*Therapeutic Gazette*, Jan. 16, 1888.

Suggestions for the Next Revision of the U. S. Pharmacopœia.

A committee appointed by the Wisconsin State Pharmaceutical Association, in a report upon the next revision of the U. S. Pharmacopœia, makes some suggestions which are of interest to physicians. From the *Phar. Era*, February, 1888, we learn that the first portion of the report refers to the nationalization of the U. S. Pharmacopœia, and to some details in the constitution of future revision committees. The specific recommendations offered with regard to the pharmacopœia itself, were as follows:

1. That in the next revision the metric system be adopted throughout, the quantities of the fluid, however, being expressed not in grains but in cubic centimeters. Should this change not be deemed advisable, rather than recede a step, it would be better to retain the present system of parts by weight, "although it is safe to say that three-fourths of the pharmacists prefer measuring liquids to weighing them."

2. That a table of maximum doses of all potent drugs and preparations to be included in the next revision.

3. That the following preparations be dropped: Elixir Aurantii, Liquor Pepsini, Acetum Sanguinariæ.

4. That the following be included in the pharmacopœia: Rhamnus Purshiana, and a fluid extract therefrom; fluid extract and syrup of Quillaia; iodol; menthol; cocaine and its salts; petrolatum carbolisatum of proper strength for the general public; oleum carbolisatum of proper strength for the same purpose; glyceritum acidi tannici, U. S. 1870; glycerites of carbolic acid, gallic acid and of borax (the latter to replace the commonly used honey of borax); tinctura iodi comp., U. S. 1870; unguentum ammonii iodidi of the same strength as the ung. pot. iod.; ether nitrosi pepsinum.

So Called Hendon Cow Disease and Scarlet Fever.

Professor Edgar Crookshank in his further report upon the so-called Hendon cow disease and its relation to scarlet fever (*Lancet*, January 28, 1888) gives the following summary of his opinions: 1. The nature of the contagium of scarlet fever is unknown. 2. The micro-organism regarded by Klein as the contagium is the *streptococcus pyogenes*. 3. The streptococcus pyogenes is found, sometimes in company with *staphylococcus pyogenes aureus* as a secondary result in scarlet fever and many other diseases. 4. A streptococcus was first observed in scarlet fever by Crooke, later by Löffler, Heubner and Bardt; but its exact relation to scarlatina and its undoubted identity with the streptococcus from pus and puerperal fever were definitely established in 1885, by Fränkel and Freudenberg. 5. Both the Wiltshire and Hendon cow diseases were called cow-pox by people on the farms. 6. Both diseases correspond in their clinical history. 7. The ulcers on the teats correspond in naked eye and in microscopical appearances, and the latter "vividly recall the appearances of cow-pox." 8. Calves inoculated from the discharges of the ulcers are similarly affected. 9. Post-mortem examination of such calves, or of calves inoculated with streptococci isolated from scarlet fever cases, show similar appearances. 10. The post-mortem appearances in such inoculated calves are the result of septicæmia. 11. There are no specific visceral changes in cow-pox apart from complications or coincident affections.

In conclusion, Prof. Crookshank promises in a further communication to publish the history of the lad shown at the meeting of the Society, the full details of the calves inoculated from the boy, and of calves inoculated from those calves, the results of revaccination of those calves, and further details from Wiltshire and Gloucestershire.

Traumatic Aneurism of the Internal Plantar Artery.

Mr. Walsham reports in the *Lancet*, January 28, 1888, a case of traumatic aneurism of the internal plantar artery of the left foot following the division of the plantar fascia for talipes equino-varus. The patient was a boy of 7 years, who was operated on in St. Bartholomew's Hospital, on July 12, 1887, for double talipes equino-varus. A sharp hemorrhage followed the operation upon the left foot, but as no subsequent trouble ensued the boy was sent home wearing a plaster bandage. On July 26, he returned, and it was then found that an aneurism had developed. This aneurism was finally cured by pressure upon the posterior tibial artery behind the inner ankle, and by pressure upon the aneurism itself, and by securing the foot and leg to a posterior splint. The patient was discharged November 6. Mr. Walsham remarks that this is the only case in which this accident has happened to him, though injury to the artery is not so uncommon. He believes carelessness on the part of the mother in permitting the child to walk about too soon, is to blame in this case.

Operative Surgery of the Male Bladder.

At a meeting of the Edinburgh Medico-Chirurgical Society, February 1, 1888, Prof. Annandale read a paper entitled, "Clinical Remarks upon the Operative Surgery of the Male Bladder," his object being to express his opinion briefly and from experience as to recent operations on the male bladder. He had performed the supra-pubic operation recommended by Sir Henry Thompson, as well as perineal section according to Mr. Reginald Harrison's method, and had come to the conclusion that the latter was the better, because the bladder was more easily drained, and the incision through the prostate did good. He advocates the operation of perineal cystotomy in the following cases: 1. In cases of constant desire to pass water, accompanied by great pain and enlarged prostate, when the ordinary treatment of catheterization and washing out has failed. 2. In acute retention from enlarged prostate. 3. For removal of tumors from the bladder. In such cases it is better to perform both operations, as greater accuracy in removing the tumor is obtained. 4. For persistent irritability of the bladder. For a fortnight after the operation he introduced a lithotomy tube, which was then changed for a short No. 14 catheter made of soft rubber, to which a tube fitted with a tap could be applied, and this enabled patients to go about their ordinary work after a time. In answer to Dr. Hodsdon, he said the tube had to be taken out and cleaned at intervals, and that there was no leakage along the sides of the catheter. Replying to Dr. Cotterill, he said that in every case he tried to incise the prostatic urethra and then the prostate upwards. The incision into the prostate, which Mr. Harrison makes on both sides, appears to have a beneficial effect in many cases of enlarged prostate.—*Medical Press and Circular*, February 8, 1888.

Personal Nomenclature.

In a letter in the *Buffalo Medical and Surgical Journal*, February, 1888, Dr. J. F. Baldwin gives the following interesting facts: "In the article on 'Nomenclature, Personal,' in 'Wood's Reference Handbook of the Medical Sciences,' occur several definitions of these several operations. As the writer of that article, I may say that these definitions cost me more correspondence than all the other five hundred put together. The definitions of Battey's and Tait's operations are quoted verbatim from letters received from each operator. *Battey's operation*—'The complete extirpation of both ovaries, while yet in a state of functional activity, for the effectual remedy of cases of disease otherwise incurable.' *Hegar's operation*—The same as Battey's operation. *Hegar-Tait operation*—A misnomer of Tait's operation. *Tait's operation*—'Removal of the uterine appendages for physical disease other than cystoma: As the removal of the ovaries and tubes for uterine myoma; the removal of a tube for pyosalpinx, or other disease; or the removal of both ovaries and tubes for chronic inflammatory disease and adhesions.'"

The object of Battey's operation is to bring about the menopause, and thus cure diseases which would be cured by the natural arrival of that period, and, hence, it has been resorted to many times for the cure of various hysterical affections. Tait distinctly disapproves of the operation, as employed for this purpose: there must be *actual physical disease*.

Penetrating Gunshot Wounds of the Cranium.

In a paper read before the N. Y. State Medical Society, February 8, 1888, on penetrating gunshot wounds of the cranium, Dr. Joseph D. Bryant said that hemorrhage should be stopped, depressed fragments of bone and all foreign bodies removed, and the wounds thoroughly drained. Statistics show that of sixty-six cases in which the bullet was removed the mortality was forty per cent., while in one hundred and seventy cases in which it was not removed, it was fifty-seven per cent. Of the recoveries when the bullet was removed, the recovery was complete in forty-one per cent., while when the bullet was not removed it was complete in only twenty per cent.

The ball should be removed immediately, when its situation can be found, but no operation should be made to search for a bullet in an unknown situation. A large, light, rigid probe must be used, and passed without force, best in such a way that the force of gravity will make it enter the bullet-wound. The ball is to be removed by a counter-opening when it lies against the opposite side of the skull, and such an opening will admit of search for and removal of the ball if it has been deflected, and also for thorough drainage. Dr. Bryant described an original method for locating the distal end of a probe passed through a bullet-wound, and recommended the telephonic probe very highly. Horsehair drainage is excellent for wounds entirely penetrating the cranium, and sometimes irrigation. —*Medical Record*, February 11, 1888.

Incontinence of Urine in Children.

In a paper on incontinence of urine in children, read before the Obstetrical Society of Boston, December 10, 1887, Dr. C. W. Townsend stated that of 355 children, 179 boys and 176 girls, taken at random among the lower and middle classes, 77 or 21½ per cent. were found to be incontinent, the limit of normal incontinence being placed at three years. The normal infants were found to stop wetting their clothes under one and a half years of age. Among the points brought out by an analysis of the 77 incontinent cases were: that 42 were boys, 35 girls, that in 47 the incontinence was nocturnal only, in two diurnal only, and in 28 both nocturnal and diurnal. In 63 incontinenee continued from infancy; in 14 it came on after the primary incontinence of infancy had ceased.

In discussing treatment, the uselessness and evil of corporal punishment in the majority cases was spoken of. In regard to the operation of circumcision and breaking up adhesions between the corona and glans, its usefulness was recognized and cases cited, but it was not regarded by any means as always curative, for other causes might be operative. The investigations of Parks, who found more or less adhesions in 80 per cent. of boys under 9 years were mentioned as showing that adhesions are far from being always a cause of the trouble. Where no other cause could be found other than an increased irritability of the bladder, the use of belladonna in full doses till physiological effects appear had generally been found to give satisfactory results.—*Boston Med. and Surg. Journal*, February 16, 1888.

Detection of Strychnine for Toxicological Purposes.

R. A. Cripps proposes the following method: He digests the solid substance in six times its weight of methylated spirit, containing a little tartaric acid. This is done for several hours at a temperature a little below the boiling-point of the spirit. The liquid is then filtered, evaporated, and the residue dissolved in 1 oz. of water, and 20 minims of spirit added. The solution, containing suspended matter, is then repeatedly shaken with a mixture of equal parts of chloroform and ether, until all coloring-matter is washed out. The chloroform washings are rejected, the aqueous fluid is rendered alkaline with ammonia, and again shaken with chloroform-ether to dissolve out the alkaloid, which again is re-extracted with acidulated water, the solution rendered alkaline with ammonia, and the strychnine finally dissolved out with chloroform-ether. The method can also be used quantitatively with very satisfactory results, if the ethereal and other liquids be washed by a second or even a third treatment with the solvent employed. To test its accuracy 0.9 grain of strychnine was introduced into a dead cat, and the stomach, etc., treated as described; 0.85 grain of pale yellowish well-defined crystals was obtained.—*Chemist and Druggist*, Feb. 4, 1888.

To Relieve Writers' Cramp.

"Canseur," in the Boston *Herald*, being asked by a correspondent for a cure for writers' cramp, replies that he is unable to name one, but offers these suggestions: Change all the conditions frequently, the height of the chair or of the table, the kind of paper, using sometimes the smoother, sometimes the rougher sort. Have every description of pen and penholder at hand, and change them frequently. Don't try to write a handsome hand, for that is something that a person who has writers' cramp in perfection cannot do. Be satisfied with legibility, and this there need be no difficulty about. The trouble seems to be a nervous one, and very little things will affect it. The change from paper that is ruled to paper that is not, and *vice versâ*, will always give relief, and even a change from black ink to blue has been known to be beneficial. Of course, you must have quill pens in your assortment, but their exclusive use will not help you. A friend who does a great deal of writing has turned to the type-writer for relief, but that is all that it affords. The fingers have got into the cramp habit, and in time the use of the type-writer wearies and stiffens them. Nothing but an infinite variety of appliances, constantly changed, will afford the desired relief.—*Ledger*, Feb. 27, 1888.

Antipyrin in Noctural Emissions.

Dr. Thör, of Beucharest, finds antipyrin an excellent substitute for bromide of potash in nocturnal emissions, being free from the objection to which bromide is liable, viz., that of producing acne. He prescribes from seven to fifteen grains in the form of tablets just before going to bed. Again, in cases of the so-called sexual neurasthenia of Beard, the same drug has proved very useful, but larger doses are required. Dr. Thör commences with fifteen grains a day, and gradually increases this to thirty grains.—*Lancet*, February 18, 1888.

Medical Men and their Fees.

The English journals announce the decision by Mr. Justice Stephen, of the Queen's Bench, of a case which is of much interest to physicians. It seems that Mr. Coumbe, a surgeon, residing at Twyford, claimed $1000 for professional attendance on Colonel Brodhurst. The latter had met with an accident on the road, which resulted in a comminuted fracture of the thigh, the treatment of which was carried out, at his request, at Mr. Coumbe's house, where the patient, with his wife and a nurse, remained some eight weeks. Sir R. Hanson having assumed the responsibility for any liabilities incurred in the treatment, sent a check for $500 on receipt of the bill, and the action was for the balance. The charges included $445 for medical attendance and $50 a week for the board and lodging of Colonel and Mrs. Brodhurst and the nurse. There were also two visits to Brighton, charged at $100 and $78 respectively. A Dr. Waugh and a Dr. Roberts gave evidence on behalf of the defendants to the effect that the charges were too high, but the jury gave a verdict for the plaintiff for $275 beyond the $500 already paid, and the $125 paid into court by Colonel Brodhurst. It was in evidence that Colonel Brodhurst was cured without deformity or disability.

Unsuccessful attempt to Blackmail a Druggist.

An attempt to levy blackmail on a pharmacist was recently made in Kieff by two young men, who are supposed at one time to have been chemist's assistants, or, at all events, to have known something about the business. They each procured from medical men, who of course had no idea that they were not treating genuine patients, a prescription. One of these ordered the preparation of an ordinary harmless mixture, the other was for an atropine lotion. They were taken to the chemist who was to be victimized, and after they had been made up the labels on the bottles were surreptitiously changed by the young men, and the unfortunate chemist threatened with a prosecution for gross and dangerous carelessness, with the object, of course, of obtaining blackmail from him as the price of not being denounced. Fortunately, however, the victim was not so easily caught, and the trial ended in a manner little expected by the young men. It was found out that they had previously played, or attempted to play, a similar trick on chemists in Moscow, and had been successful in obtaining blackmail to the extent of about 250 dollars. They were ordered to be sent to Moscow.—*Lancet*, Feb. 4, 1888.

Prohibiting the Sale of Secret Medicines.

A bill which practically prohibits the sale of secret medicines has been introduced into the Assembly of the State of New York by Mr. J. W. Smith. It provides that no person or firm shall sell any medicinal preparation without filing the formula of the preparation with the State Board of Health and receiving a license or certificate from that body. It further provides that no so-called secret or proprietary medicine shall be sold, unless there is a printed formula showing the nature of the compound on the bottle, and also the words, "Sale authorized by New York State Board of Health."

It seems a very simple and manifest proposition that the public should be protected against the enormous swindling of the patent-medicine trade. And such a bill as the above would certainly promote the public good. But we fear that vested interests will prove too strong for it. The propriety of a printed indorsement by the State Board of Health might be questioned, in any event.—*Medical Record*, March 3, 1888.

Abscess in the Middle Ear mistaken for Toothache.

In the *St. Louis Med. and Surg. Journal*, March, 1888, Dr. A. D. Williams says: "Early in February a young man had what he took to be toothache on the right side of the upper jaw. He consulted a dentist, who could find nothing wrong with the teeth and referred him to me. On examination I found a well-marked abscess in the right drum. The upper back portion of the membrane was bulged outwards to the extent of a pea. When punctured, pus escaped at once, and when air was blown through the drum considerable more was forced out of it. I need hardly add that this promptly relieved the "toothache." Reflex irritation between the teeth and the ear is usually from the former to the latter. In this case the usual order was reversed."

Monobromate of Camphor in Epilepsy.

Dr. Campbell Black recommends the following formula in the *British Med. Journal:*

Monobromate of camphor..... 37½ grains
Extract of belladonna.....6 "
Extract of gentian, q.s. to form pill mass.
Divide into 12 pills. One to be taken morning and evening, or in severe cases, three times a day.

Typhoid Mortality in France.

According to the *Lancet*, February 4, 1888, M. Chamberland, chief of M. Pasteur's laboratory, has been writing an important report demonstrating the unsatisfactory character of hygiene in France. He finds that in the French army typhoid fever kills no less than 3.78 per 1000, while the typhoid mortality in the English and German armies is 0.84 and 0.19 per 1000 respectively. Again, the deaths from this disease per 100,000 of population are 63 in Paris, 148 in Marseilles, 19 Brussels, and 17 in Berlin and London. A critique on this report, published in a Lyons medical journal, points out that, in addition to faulty hygiene, antiquated methods of treatment usual in France may have something to answer for. In Lyons, which is the only French city in which the cold-bath treatment of typhoid is much practiced, the typhoid mortality per 100,000 inhabitants is much lower than in Paris, being variously estimated by M. Chamberland and his critic at 42 and 31, per 100,000.

Charming Away Warts.

"In visiting a country asylum, some years ago," writes Dr. Luke, "my attention was directed to several of the patients and nurses who were pestered with warts, and I solemnly charmed them away within a specified period. I had quite forgotten the circumstance until, on re-visiting the institution a few months after, I found that my practice had been followed by the desired effect, and that I was regarded as a real benefactor."—*Southern California Practitioner*, February, 1888.

The Age for Revaccination.

The Local Government Board has issued an order reducing the age limit for revaccination from fifteen to twelve years, under ordinary circumstances, and to ten years in case there be any immediate danger of smallpox.—*Lancet*, February 18, 1888.

Forty Years a Physician.

On March 13, 1888, Dr. James L. Stewart, one of the best known physicians of Erie, Pa., had the pleasure of gathering round him a large number of friends to celebrate the completion of his fortieth year of work in the medical profession. The celebration took the form of a dinner, followed by speeches of praise and congratulation, and the reading of a large number of letters from admiring friends in different parts of the country.

A full account of the proceedings was published in the *Erie Weekly Dispatch* of March 14.

NEWS.

—The Long Island Medical College Hospital held its annual Commencement March 9, and graduated a class of thirty-six.

—The Bellevue Hospital Medical College held its Commencement March 12, and graduated a class of one hundred and forty-four.

—Dr. Edward P. Davis has been elected Attending Obstetrician, and Dr. Wharton Sinkler Neurologist, to the Philadelphia Hospital.

—Sir Henry Acland has been obliged to submit to an operation for hemorrhagic glaucoma of the left eye. He is reported to be doing well.

—The 36th Annual Commencement of the Woman's Medical College of Pennsylvania, was held at the Academy of Music, March 15, 1888. Dean Bodley delivered the address to the graduates.

—Dr. Bramann has had the Commander's cross of the Hohenzollern House Order bestowed upon him by the late Emperor of Germany, for his skilful performance of tracheotomy upon the Crown Prince.

—A dinner to Prof. Agnew, on the completion of the 50th year of his doctorate, will be given by his colleagues in Philadelphia, in the Foyer of the Academy of Music, April 6, 1888, at 7 P.M. It has been decided to ask Dr. Agnew to sit for his portrait.

—Professor Austin Flint will deliver the annual oration before the Alumni Association of Jefferson Medical College, in the amphitheatre of the Hospital, on the evening of April 2. After the oration he will be given a reception at the Hotel Bellevue.

—A society has been formed in Paris for the purpose of special study of diseases of the mouth. This "Stomatological Society" has given occasion to different journals to grow witty over the possibilities in nomenclature which may arise from this tendency to sub-division in titles.

—The Royal Academy of Medicine and Surgery of Barcelona, announces that the Gari prize of $300 will be awarded this year for the best essay on the Pathogenesis of Gonorrhœa, giving clinical forms of the affection, with special reference to prolonged cases and cases of repetition; concomitant and consequent affections; prophylactic treatment. Illustrative specimens are to be sent with the thesis, which must be sent accompanied with a motto in the usual way. The essays may be written in Spanish, French, or Italian, and must be sent to the Academy before June 30, 1889.

HUMOR.

In order to cure whooping-cough in Warwickshire, England, they cut a piece of hair from the nape of the child's neck, chop it very fine, and spread it on a piece of bread and give it to a dog.

Bobby—Ma, did the doctor bring me in the daytime or nighttime? Mother—In the nighttime, Bobby. Bobby—Well, I guess that's the reason I don't remember anything about it. I must have been asleep.

Sorely Affected.—Mrs. Cloony—I'ts sorry Oi am t' hear Mike do be shick, Norah. Pfwhat ails th' man? Mrs. McManus—Keen fer him, Kathie, keen fer him. Th' docther's after sayin' he has a mannerism an' th' hear-rt av him.—*Tid-Bits.*

Anxious Arkansaw Mother.—"Tommy, is that a green persimmon you air eating?"

"Yes, maw."

"Don't you know it ain't healthy to eat green persimmons on an empty stomach?"

"I ain't eatin' this green persimmon on an empty stomach; I ate a peck of 'em before I tackled this one."—*Texas Record of Medicine.*

Tramp (to fussy old gentleman): "Will you please give me ten cents, sir; I'm starving?"

Fussy old gentleman (producing a bill): "Dear me, starving. Can you change a dollar?"

Tramp: "Yes, sir."

Fussy old gentleman (pocketing the change): "Dear, dear, starving! Bless me, but this world is full of misery!"

Almost given away.—Prospective buyer—"You're sure there's no malaria here?" Real estate agent—"Not a s-s-sign of it." Prospective buyer—"No chills and fever?" Real estate agent—"Ain't b-b-been none in t-t-t-t (excuse me) twenty year." Prospective buyer—"Look here, my friend, what makes you tremble so?" Real estate agent (as another wave of shakes passes over him)—"I was a-a-fraid you were g-g-goin' away without buyin', sir."—*Puck.*

OBITUARY.

CARY R. CLEWELL, M.D.

Dr. Cary R. Clewell died at his home in Telford, Pa., March 8, 1888. He was graduated from the Medical Department of the University of Pennsylvania in 1887.

JOHN M. TIMMONS, M.D.

Dr. John M. Timmons died in Whaleyville, January 15, 1888, of phthisis. He was born September 7, 1859, and was graduated from the Jefferson Medical College in 1883. He practiced in Philadelphia till the fall of 1886, when his health failed. He travelled through the West and South for his health, but deriving no benefit returned to his home in Whaleyville, where he died.

F. R. S. DRAKE, M.D.

Dr. F. R. S. Drake, of New York, died in New York, March 11, in the forty-third year of his age. He was graduated from the University of the City of New York in 1871, and was for a time Professor of Clinical Medicine in that College, and visiting physician to the Bellevue Hospital.

WILLIS W. FRENCH, M.D.

Dr. Willis W. French died in New York, March 11. He was graduated from Bowdoin College in 1878, and from the College of Physicians and Surgeons, New York, in 1883.

CHARLES G. STEELE, M.D.

Dr. Charles G. Steele died in Buffalo, N. Y., February 11. He was graduated from the Medical Department of the University of Buffalo in 1886. He was business manager of the *Medical Press of Western New York.*

HENRY P. AYERS, M.D.

Dr. Henry P. Ayers died in Fort Wayne, Indiana, December 28, 1887. He was graduated from the University of the City of New York in 1846.

Official list of changes in the Stations and Duties of Officers serving in the Medical Department, U. S. Army, from March 18, 1888, to March 24, 1888:

Col. J. H. Baxter, Chief Medical Purveyor, will proceed to Augusta Arsenal, Ga., on public business. S. O. 62, A. G. O., March 16, 1888.

Major Wm. C. Spencer, Surgeon, died March 22, 1888, at Fort Trumbull, Conn.

Major Chas. R. Greenleaf, Surgeon, will proceed to Cambridge, Mass., on official business. S. O. 62, A. G. O., March 16, 1888.

Major W. H. Forwood, Surgeon, granted one month's leave. S. O. 20, Dept. Dakota, March 10, 1888.

Major H. E. Brown, Surgeon, assigned to temporary duty at Fort Banancas, Fla., during the absence on leave of Assistant Surgeon M. C. Wyeth. On the return to duty of Capt. Wyeth, Major Brown will rejoin his proper station. S. O. 65, A. G. O., March 20, 1888.

Major R. M. O'Reilly, Surgeon, will proceed to York, Pa., and make an examination of Capt. Edw. B. Rhum, 21st Infantry. S. O. 62, A. G. O., March 16, 1888.

Capt. J. C. Worthington, Assistant Surgeon, granted leave of absence for four months, to take effect May 15, or as soon thereafter as his services can be spared. S. O. 65, A. G. O., March 20, 1888.

Capt. M. C. Wyeth, Assistant Surgeon, granted leave of absence for two months, to take effect about April 1. S. O. 65, A. G. O., March 20, 1888.

There have been no changes in the Medical Corps of the Navy, for the week ending March 24, 1888.

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Communications.

CASE OF SUCCESSFUL SIMULTANEOUS TRIPLE AMPUTATION FOR RAILWAY INJURY, WITH REMARKS ON THE TECHNIQUE OF MULTIPLE AMPUTATION.[1]

BY JOHN ASHHURST, JR., M. D.,

PROFESSOR OF CLINICAL SURGERY IN THE UNIVERSITY OF PENNSYLVANIA; SURGEON TO THE PENNSYLVANIA AND UNIVERSITY HOSPITALS, PHILADELPHIA.

The patient is brought before the College largely on account of the rareness of simultaneous triple major amputations. It is quite possible that some of the Fellows may not have had an opportunity of seeing such a case.

The patient is a Moor, twenty years of age. He was admitted to the University Hospital, November 28, 1887, having been run over on the Pennsylvania Railroad. I saw him within two hours after his admission. I found a compound comminuted fracture of the right leg, the laceration extending above the knee; complete avulsion of the left leg, the limb having been torn off in its lower third; and a compound fracture of a severe character of the right hand and wrist. There was also a compound fracture of the skull, involving the frontal bone. This, however, was an impacted fracture, of course without much depression, and did not require interference. In addition to these injuries, there were numerous brush-burns and contusions, some of a grave character. One upon the left buttock was so severe that the separation of the slough left a cavity fully two inches in depth. Notwithstanding these serious injuries, the patient's general condition was very good; he had reacted thoroughly, and his axillary temperature was 99° F. Under these circumstances, I felt justified in proceeding to the immediate removal of the injured limbs, and amputated successively the right thigh by the antero-posterior flap method; the left leg, about its middle, by a modified Sédillot's external flap operation, the modification consisting in making both flaps from without inward, instead of cutting the external flap by transfixion; and the right forearm by an oval incision, making use of the uninjured skin of the back of the hand and wrist. Certain variations from the ordinary procedure in amputations I shall refer to when I come to speak of what I have ventured to term the technique of multiple amputations. After the operations were completed, the temperature had fallen only to 98° F. The patient had no bad symptom and rapidly recovered, and as you see him now all his wounds are perfectly healed, and he is entirely well.

I have collected some statistics of synchronous multiple amputations. I am able to find but one instance of *quadruple* synchronous amputation—a case in which the operations were done for frost-bite by Dr. George E. Jackson, of Dakota. There are several cases recorded of quadruple amputations, not synchronous, the one which approaches nearest to a synchronous operation being that of Champenois, a French surgeon, who amputated three limbs on one day, and the fourth a few days later.

Of synchronous triple amputation there have been reported four successful cases, not including that presented to-night; one by Dr. Köhler, of Schuylkill Haven, Pa.; one by Dr. Lowman, of Johnstown, Pa.; and two referred to by Professor Agnew, in his *Surgery*, one occurring in the practice of

[1] Stenographic report of a verbal communication made to the College of Physicians, March 7, 1888.

Dr. Stone, of New Orleans, and the other in York, the name of the surgeon not being given. There are reported four or five triple amputations not synchronous. I have myself resorted to synchronous triple amputation in two cases. Several years ago, I had occasion to perform this operation, removing both legs and the right forearm of a man, aged forty-five years, of intemperate habits. The patient died on the tenth day, the fatal result being due rather to the visceral lesions resulting from alcoholism than to the operation.

Double amputations are comparatively numerous. I have personally performed fifteen such operations, this number not including two successful cases of double partial amputation of the feet. I have done fifteen double major amputations, of which five have ended in recovery. One of the patients who recovered, I had the honor of exhibiting to the College some years ago; the amputations in this case were through the right hip-joint and through the left leg. In the fatal cases, seven of the deaths occurred within less than one day, and were, therefore, the immediate result of the shock of the injury and of the operation. Three patients died, one in three days, one in four days, and the third in eighteen days. The latter would probably have recovered, but that he also had suppurative disease of the middle ear, which appeared to be the cause of the pyæmia which proved fatal; for when the stumps were examined, after death, they were found to be in good condition.

With regard to what I have termed the technique of multiple amputations, there are some points which my experience justifies me in urging upon surgeons as of importance in promoting success. In the first place, it is very important that the time occupied by the operations should be brief; that the operations should be done systematically, so as to keep the patient under the anæsthetic as short a time as possible. The next point, perhaps of even more importance, is to keep up the temperature of the patient during the operations. I have been led to think that this is, perhaps, of more importance than anything else. Of course, loss of blood must be scrupulously guarded against, and loss of blood directly causes loss of temperature. In this case hot cans were kept around the patient during the entire operation; and, in order to save time, I operated systematically, the tourniquet and Esmarch bandage being both employed to prevent any loss of blood. I began with the most serious injury, and this is, I think, a point of importance. It may happen that, after the removal of one limb, it will be found that further operation must be postponed on account of the patient's condition, and then it is, of course, better to leave him with the less severe injuries. In this case, I began with the thigh. After amputating the limb, I secured the main vessels, which were readily found. I attempted to tie the arteries with catgut, but as the ligatures broke, I substituted silk, and, in order to save time, left both ends uncut. I next amputated the right leg, securing the vessels in the same manner, and then passed to the forearm. I then came back to the right thigh, screwed up the tourniquet and removed the Esmarch bandage, and secured all the vessels that required ligature, then passing to the other limbs in the same order as before. After the vessels had been secured in each case, a towel dipped in a hot antiseptic solution was placed between the flaps. The wounds were then dressed in the same order, and in this way the operation was completed in a comparatively short time.

The points which I have mentioned I believe to be of great importance, and I think that much of the disappointment of surgeons from these operations is due to a want of attention to these matters.

I should also say that, in order to preserve the bodily heat, I did not use irrigation during the amputations. I think that this often seriously reduces the temperature; and even in comparatively slight operations where it has been used, I have seen the temperature fall to 97° F., and even 95° F. I think that in any grave case, it is better to omit it and to rely upon washing with hot antiseptic solutions before and after the operation. Also, the packing of wet towels around the seat of operation, as is very commonly done, tends to depress the temperature, and in grave cases should be omitted.

I think that it is to an observance of these precautions that I have owed success in this case, and in many other serious operations of various character.

—A party of soldiers in Paris was engaged in firing blank cartridges, when one of them, Carre, put a bullet into his rifle by mistake. When the word was given, Carre, who was in the rear rank, fired with the rest, and his bullet lodged in the head of his front-rank man. The captain in charge dropped dead from heart disease when he saw the soldier fall, and Carre endeavored to kill himself, but was prevented. The bullet was successfully extracted, and the injured man will probably recover.

ESSENTIALS: NON-ESSENTIALS.

W. M. HEPBURN, M.D.,
FREEHOLD, N. J.

A feeling bordering on despair must sometimes fill the heart of every earnest student and practitioner. Difficulties meet him, both in his reading and in his efforts at the bedside, which seem insurmountable, and make him wonder just what he knows about drugs, and doubt if there is much to know. Like the able writer in the *Record*, August 21, 1886, in the article, "What Can We Cure?" who sums up his list of lithontriptics, emmenagogues, expectorants, etc., as worse than useless, and also adds: "Ringer is quoted as a believer in specific medication, while his book goes through six annual editions, yet his most vaunted remedies are for functional disorders. A good physician's highest hopes are realized when he has by opium assuaged pain, and by alcohol kept the heart wagging in the decline of some violent malady."

He even robs us of what a prominent surgeon once remarked to me, were all the drugs we could see results from, viz., iodide of potassium and mercury, quoting Diday as saying: "Syphilis is cured by the grace of God;" and he deals the final blow in these words:

> "Like blind men fighting in the dark,
> They never fail to miss the mark;
> When death doth fail, the doctor's sure
> To meekly stand and claim the cure."

It is not alone in the materia medica and therapeutical world that we are met by such truths, or partial truths. If we try to acquaint ourselves with the cause of disease, we find the same apparent difficulty in knowing just what to accept and what reject. We may give our whole belief to the theories of some brilliant writer, but that does not settle the matter. What is the truth? That is what we wish to know.

In a gathering such as the International Medical Congress, we have an opportunity to see how diametrically men differ. As I read my journal to-day in regard to pneumonia, I find one writer says: "The day is seemingly not far distant when we shall speak of pneumonic fever in precisely the same way as we use the term enteric fever at present; that is, to signify a zymotic or specific blood disease manifesting itself after the lapse of a certain time—the period of incubation—by physical phenomena, objective and subjective, connected in this instance with the lungs." Yet the very next essay is by one who thinks that nearly all of the pneumonias seem to be accounted for without the necessity of supposing a special contagion: cold, dry air, according to this writer, is the great factor in acute pulmonary inflammations.

But why multiply cases? Even in regard to bacteriology, we are informed by an authority, that the only experiments made which have given satisfactory results are those in carbuncle and tuberculosis. As the same writer says: "To conclude hastily that this or that microbe is the cause of any disease is but to ignore or set aside experimental method. The demonstration which the experimental method demands in this case would be complicated, because we would not only have to know that the microbe existed, but we would have to know what was the condition of the blood necessary to the culture of that particular microbe; and science tells us that, for the present, this is a problem we cannot solve." When the innumerable facts of our medical world face us, when we are met by such an array of truths, and attempt to even contemplate the amount of research it will necessite before we see clearly, and not through a glass darkly, we feel our helplessness, and can appreciate the old professor's view of his life which has been spent in the study of one Greek word, and which he thought had been too broad a subject.

But although we see the difficulties, yet we have patients lying on beds of suffering, and, maybe, death. Our *lack* of knowledge cannot be of benefit to them. In our ignorance what are we to do? Certainly the best thing to do is to grasp what has been given to us in the present state of medical knowledge, and to be able to appreciate what is essential, and what not. I truly believe that drugs are meant to be more than mere palliatives; that they have virtues which should make them curative, but that we will never learn what those virtues are until we have first had *preventive* measures *ground into us*. Surgeons performing operations realize the necessity of banishing everything of a contagious character; the dangers of an operation unless they are vanished, but it is hard to impress upon physicians, as a whole, especially when they have pure country air about them, that it is *the* treatment of the present time.

How many perfectly isolate cases of scarlet fever, measles, diphtheria? How many disinfect typhoid and all suspicious stools? How many rooms are thoroughly disinfected after contagious diseases?

I recall a house where last spring I attended three cases of severe attacks of scarlet fever,

in the poorer part of the town. Just while it was at its height I happened to see a large wagon filled with clothes stop there and the driver take a bundle into a room but a little distance from where the patients were all lying. This bundle of cut cloth was to be sewed and then sent back to the factory. I imagine what the result might have been had I allowed the cloth to be left. This house consisting of two rooms filled with old furniture, must have been saturated with germs. I spoke earnestly to the inmates and to one of the health authorities about having the house thoroughly disinfected. I do not think it has been done. And is it an unusual case? Are the great majority of infected houses properly disinfected?

So in another house where two of three children died of diphtheria, a neighbor came unasked and not needed, to sit where the children were. I told her to go home, and was answered that she had been with such cases before and was not afraid, yet she went directly from there to her nursing baby. What an absurdity to pour iron and potash, or any other drug down the throats of the children of such parents. We do not see results as rapidly, from proper care of cases, as does the surgeon; but just as primary union is the usual instead of the exceptional result of operating in the present day, because of vigorous attention to proper surgical surroundings, so will our mortality list be larger or smaller according to our ability to appreciate and rectify the harmful surroundings of our patients. The ignorance in regard to hygiene is appalling. A patient complained to me of his well-water tasting and smelling badly, and on investigation I found his neighbor's cesspool was only twenty-five feet away, and had been there for years. Yet this same neighbor—a man standing well in the business world as a man of sense and sagacity—was amused to think that his cemented cesspool which, though old, was twenty-five feet away, could contaminate the well.

But our knowledge is limited, and as we have diseases which, to us, are non-contagious and non-preventable, what can we do for them? Are opium and alcohol our only standbys? Immediately the fact presents itself that mere prescribing is not the whole duty of a physician. And when we speak of curing disease we connect with that expression the thought of work thoroughly done. Pure air, perfect isolation, suitable and nourishing food, good nursing. How much this means. "High and low, rich and poor, the wise man and the fool, rival in ignorance of the absolute need to health of a limitless supply of fresh, pure air. Their dainty stomachs will reject unsavory food, their delicate hands shrink from the touch of unclean things; but they will greedily and recklessly take into their lungs to be incorporated in themselves viler nuisances than any of the visible filth they have smelt or touched or tasted, for notwithstanding its æriform condition it is as much filth as the fetid ooze of the sewer or solid putrescence of decomposition." Rich and poor suffer from ignorance in most matters where the health is concerned. As one says in regard to Bobbie's eating: "Nobody thinks of refusing to give him kidney, fried potatoes, buckwheat cakes, or coffee. His mother could not decide if questioned, which of these is wholesome fare for infants * * * He lives through it? Why—yes—generally. That is, he does not always and immediately die as the unmistakable result of the poison. His system takes care of it somehow, or gets rid of it somehow else. If, by the time he is thirty, the long suffering stomach will pay no more debts of his contracting, who reckons why the trial-balance does not come out right? He lived through scarlet fever, but it left him slightly deaf; the measles kept him prisoner all of one winter, and his eyes have been weak ever since * * * Not even the always vigilant mother thinks of associating childish excesses with the lad's sick headaches or the man's defective digestion."

In spite of what we do not know how our field broadens as we contemplate our duty; what evidences we gather by simply opening our hearts to them, of the needed medical educators, oh, and how it adds to the dignity of our noble profession to be, not alone drug prescribers—even though they be specifics—but the health *preservers* in the families which we attend.

But more than this as an eminent writer says: "Indeed, the methods, even those the outcome of the most conclusive experimental science and of the most perfect mechanical treatments, must ever take cognizance that in treating the sick we are dealing with the man in disease, *quite as much* as the disease in the man. However more exact our means, however larger our resources, the personal something in the sick, the personal something in the physician will never cease to have their power. And the greatest success will always be with the greatest measure of tact, with the quickest appreciation of vital strength, with the magnetic influence which instils confidence and trust with the fullest inspiration of hope, as well as with courage that knows when to take risks and the wisdom that knows when to rest."

But there are many more facts confront us outside of care for our patients and the personal magnetism of the physician.

One of these is the question of the use and effects of drugs. One reason we do not see *direct* results from medication is because we fail to recognize the disease.

When in the Pennsylvania coal region I recall being requested, by a woman, to give her some ointment for hemorrhoids as her husband had suffered and was then suffering from them. The ointment, with advice as to care in other respects, was given. Next day I was again stopped, as I passed through the town, and requested to give something better. Fortunately I decided to go in the house and see the patient. Examining the parts and not seeing evidence of much trouble, I introduced my finger into the bowel and feeling some hard body lying across the bowel; I passed my finger above and around it (causing great pain) and pulled out a splinter of wood at least one and one-half inches long, blunt at one end and pointed at the other. The man could give no history whatever to account for its presence.

A second reason is, it is sometimes impossible to know just what causes the trouble. I have a patient, an adult, who four years ago fell while walking on the street and had a severe convulsion. It was his first and last. The heart and urine were examined, but nothing abnormal was detected, and a heavy meal was supposed to have caused the attack. A few months since he developed hemianopsia.

Thirdly, even when we detect the disease we do not always do reasonable things. It is seldom one meets a physician who cannot tell him about the latest drugs; but one cannot have much knowledge of the treatment of many doctors without being conscious of the fact that there is yet a wild search after "that specific," and often the poor sufferer is taking three or four distinct combinations, and, as I have seen, *not a teaspoonful* of nourishment.

But how is it possible to speak of the questions which present themselves to the physician in every very sick patient which he must answer for himself, which books cannot aid him in, and on his treatment may depend the life of the person. I have now a convalescent case from that common disease, acute articular rheumatism, which presented just such questions. A man about 28 years of age, German, evidently a sufferer in early life from Pott's disease. Had once before had a long, tedious attack of rheumatism. By exposure he was prostrated in December, and when I saw him he was entirely helpless. From the first he showed symptoms of great prostration. Pulse rapid and weak, breathing short and about thirty respirations to the minute, pain excessive. Gave alkalies, anodynes and food. Retained his food and medicine nicely, but the opiates caused obstinate constipation, and after some days his breath became very offensive, tongue heavily coated and dry, and vomiting threatened—which same would have made his chances few. What shall we do? I gave, with difficulty, an enema. He retained it and had no movement. A purging would cause intense pain from repeated use of bed-pan, and his prostration was too great to allow of it. Decided on one-tenth grain of calomel every hour for six hours, followed by teaspoonful doses of magnes. sulph. every four hours. Result, moist tongue, better digestion, and easy and large movement. If we do well in all such emergencies do we not assist in curing the patient?

As to the specific action of drugs, I know of no specific for any disease, but I have seen drugs act like specifics.

Certain medicines will do well in certain people, and utterly fail in others. Certain drugs will accomplish desired results when combined, when separately they are seemingly useless. I have seen persimmons and whiskey combined literally raise up a man suffering with cancer of the bowel, control a desperate diarrhœa and prostration, when stimulants with anodyne sedatives and everything else utterly failed. In other cases the combination had no good effect.

A case of chorea of very unusual severity markedly and rapidly improved by the use of *strychnine* after *all* the usual and unusual remedies had been tried in vain. We will yet learn *why* these things are so. At present we are necessitated to be empiricists in much of our treatment, but the thoughtful, observing, practical physician learns more every day what is essential and what not, and in using his knowledge does aid in curing disease.

—Dr. F. M. Hamlin, a prominent physician of Auburn, N. Y., was removed to an asylum at Utica, on March 23, as a victim to the morphine and cocaine habit. He was an expert microscopist, and a year ago was commissioned by the British Government to go to the Bermudas and investigate the causes of the onion blight. He made an elaborate report. For several years he has made a study of the morphine habit and has made a specialty of treating patients addicted to it, and notwithstanding this fact has succumbed to the habit himself.

ELECTROLYSIS *VERSUS* OÖPHORECTOMY.

BY WILLIAM R. D. BLACKWOOD, M.D.,
PHILADELPHIA, PA.

For some years past I have intended suggesting the use of strong currents of electricity with a view to destroy the functional activity of the ovaries, but other matters have occupied my time and prevented my doing so. The communication of Dr. Kimball, in the REPORTER for March 3, has renewed my desire to offer the experience resulting from four cases in which ovulation has, I believe, been thus destroyed. The relation of menstruation to ovulation has not been settled yet, nor has it been demonstrated that the menopause depends upon the ceasing of menstruation or ovulation alone. Surgical removal of the ovaries and the tubes does not invariably prevent the monthly flow, although it usually does so. I have seen well-defined menstruation occur in women who have undergone ovariotomy, and Tait's operation singly or combined, and although the flow was neither free nor regular it was considered by the women as menstruation, and to me it was such. I do not believe that electrolysis would be advisable in many cases, nor would it supplant the furor for doing abdominal section, which so many young men (and women) feel that predestination has forced upon them. Electricity makes no fuss, leaves no puckered scars, sheds no blood, and can't exhibit the "specimens" to the gaping public in the doctor's sanctum, but I believe that in selected cases it will annihilate functional activity in these pestiferous organs which have mysteriously bothered women for a few years past. Let me illustrate.

In the last twenty years I have treated with localized electricity in its three forms a little over eleven hundred cases of ovarian neuralgia, or of general nervous disturbance believed to be dependent on ovarian congestion or inflammation, with or without associated uterine disease. Although I sometimes employed Faradism and static electricity, the great majority were treated by galvanism, and rarely with currents of more than fifty milliamperes. In some as much as two hundred milliamperes were used, and a profound impression of course resulted. I reported a few of my earlier cases, but as professional attention was not directed to electrolysis at the time, I ceased doing so. At a meeting of the Philadelphia County Medical Society ten or twelve years ago, the late eminent gynæcologist Dr. Albert H. Smith, condemned my use of from one hundred to two hundred milliamperes intra-uterine, and he was supported by others in his remarks, who, from all I can learn, never owned anything beyond a cheap Faradic machine either then or now. The three cases reported then as cured of membranous dysmenorrhœa and menorrhagia were (unknown to him) women who were unrelieved by his services, yet they remain cured to-day by my unwarrantable and inexpensive treatment. Apostoli wasn't around then.

1. In a case of extra-uterine pregnancy treated by high Faradic tension,[1] together with galvanism, the patient had given birth previously to three children, but since the electrolysis ovulation is apparently suspended or abolished; I believe it is destroyed. From a previous menorrhagic habit she is now scanty in her flow, and she wants fifteen years, at least, before the menopause is due. I sent a current of three hundred milliamperes through her ovaries twice for ten minutes, and a Faradic secondary of 7″–12″, first on one side and then on the other, for an hour, several times. The current traverses the uterus, the tubes, and the ovaries, in all applications. A complication which for nearly three years thereafter worried her and myself, was peristent chronic diarrhœa due, I feared, to paralysis of the intestinal muscular fibre from diffused currents. It was impossible to prevent this side-escape, or to isolate the pelvic nerve-trunks, hence I supposed the diarrhœa due to molecular destruction of portions of either tissue. Now I know better—it was masked intermittent, and was cured by arsenic and opium in very small doses, after failure of every known astringent or remedy against diarrhœa, suggested by professional friends.

2. Another case was that of a woman with chronic ovarian congestion, and in her I used Faradism to her utmost ability to stand it. The rheophores were applied, one over the glands singly, and the other in the uterus. After half a dozen seances her malady quit, and her health returned. She is only twenty-two, but she has ceased menstruating for two years. Her general health is exhuberantly perfect.

3. Again, another ovaralgia case, treated by galvanism and Faradism. Six weeks of moderate electric treatment was negative, and as she was a personal friend, as well as my patient, I was desirous of curing her; hence, I increased the doses to the utmost capacity bearable without anæsthesia. A few applications relieved her for a year, and on a threatened return I gave her a single

[1] *Medical Bulletin*, May, 1885.

dose of two hundred and seventy-five milliamperes, followed next day by Faradism up to 12″. She dropped her ovaralgia, and her ovulation also, I think. At any rate, she used to suffer for three or four days after menstruation ceased from pain, which stopped when accompanied by a little hæmorrhœa lasting only an hour. Her periods now are also scanty, short and painless; she has no secondary discharge. I believe ovulation occurred under the last flow, (that lasting an hour or so), and she is now sterile, or has been for several years. She was productive before the electrolysis.

4. The last case referred to is that of a woman presumably suffering from incipient cystic ovarian disease. Tumor was hereditary in her family, and she dreaded ovariotomy. I used strong electrolysis twice weekly for three months, and the swelling disappeared. So did ovulation, I am sure, although she menstruates regularly but scantily, when compared with her usual manner prior to the feared cystic development. She conceived and aborted three or four times a year before the electrical treatment—now she is barren, for there is no lack of trying to be a mother and her husband is all right.

If electrolysis did not destroy ovarian function in these cases, how can the subsequent history of apparent sterility be explained? That weaker currents than such as were used by me in the cases instanced will disorganize ovarian tissue, in recent specimens I know from abundant experiment. Why, therefore, should not very powerful currents do so in the living subject? Improper electrical treatment has utterly ruined many cases of paralysis, both infantile and in the adult, as every neurologist can testify; and electrolysis long continued will destroy the function of both nerve and muscle—why won't it do so in ovarian stroma?

The only question as I see it is the selection of cases, the method of application, and the attention due to the safety of the woman. I don't like a big abdominal poultice for the positive even if it is Apostoli*cal*. I prefer a well localized cataphoric rheophore not over two inches in diameter. It won't produce sloughs with care under galvanism, and Faradism won't do harm anyhow. There is more skill required in applying the vaginal rheophore, which must have a bare ball or disk. We can alter its position considerably from time to time, yet reach the ovary. I mean to try electrolysis for the purpose indicated hereafter, and I shall report the result. If electro-therapeutists will also experiment a little, something may come of it.

ON THE IMPORTANCE OF PRIMARY SUTURE OF DIVIDED NERVES, WITH AN ILLUSTRATIVE CASE OF SUCCESSFUL SUTURE OF THE MEDIAN AND ULNAR NERVE.[1]

BY CHARLES B. NANCREDE, M.D.,

SURGEON TO THE JEFFRESON MEDICAL COLLEGE HOSPITAL AND TO THE EPISCOPAL HOSPITAL, PHILADELPHIA.

Although I have a most profound faith in the vis medicatrix naturæ, I still think that Dame Nature should always have fair play in her battle with injury or disease, and this she certainly fails to receive at the hands of too many practitioners. In a paper published some fifteen years ago, I contended that, if with such vascular structures as those of the face, which certainly would unite sooner or later in some sort of fashion, we habitually resorted to suture, merely for cosmetic effects, we were all the more bound to do so for such vascular structures as tendons, which, if they failed to heal well, much more if no union was secured, must entail disability or total uselessness of a member. Nowadays a surgeon who should fail to suture a divided tendon would be considered derelict in his duties. In like manner, I trust, that in the near future the general practitioner will be so impressed with its importance that he will consider that his duty is unfulfilled until he, or some surgeon summoned by him, has sutured any divided nerve. It is needless for me to dilate upon the evils consequent upon the abolition of function of an important nerve, but I would recall to your minds cases which must have occurred in the practice of most of those present, where divisions of even such small trunks as digital nerves have resulted in troublesome ulcerations, causalgias, etc.

Doubtless the indifference of practitioners to wounds of nerves, or, more strictly speaking, their inclination to "leave them to Nature," has arisen from two causes, viz., (1) the fear that suturing might in some way determine tetanus, and (2) the well-known fact that nerves divided or even excised with the avowed intention of abrogating their function, too commonly reunite. The first cause should not deter us, as we now know that a suture, *per se*, can never originate tetanus; while as to the second objection, certain facts which I shall submit for your consideration warrant the conclusion that traumatic divisions of nerves, unless effected

[1] Read at the meeting of the Philadelphia County Medical Society, March 14, 1888.

by a clean cut—or perhaps ball wounds—involving solely the nerve and little, if any, of the contiguous structure, differ so materially from those purposely effected by the surgeon's knife, that conclusions derived from the result of neurectomies cannot safely be applied to accidental divisions of nerves. Besides, granting that reunion will occur without suturing, as a stitch can do no harm, why not use one, since it will at least conduce to a more rapid resumption of function? While primary union of nerves with immediate resumption of function—*i. e.*, in a week or ten days, is a surgical rarity, yet it does at times occur, and would doubtless be of more frequent occurrence, if suture were the rule and not the exception.

My aim in this brief note is merely to call your attention, as general practitioners in whose hands many of these cases will fall, to the *duty* of suturing divided nerves as a routine practice, just as you would tie arteries, and to describe a simple, effective method of carrying out the indication. A critical examination of the histories of nearly all exsections of nerves where reproduction has occurred, will show that they were removed either from a bony canal or from an intermuscular space in which they normally laid, *with the minimum* of injury to the surrounding tissues. Moreover, even when their ends have been turned back and sutured in position, or even buried in the surrounding tissues, they have been so secured in the same intermuscular space which the nerve normally traverses. In other words, the bony canals and the intermuscular spaces likewise, act as moulds which direct the course of the reparative material from the proximal to the distal end of the severed nerve. In extensive wounds, however, this condition does not obtain. Intermuscular spaces are dislocated, large masses of scar tissue are formed, so that instead of the new nerve-tissue being *compelled* to grow in only one, and that the right direction, it has too often an insuperable barrier interposed, and union fails.

In the case which I now show you,[1] the proximal ends of the ulnar and median nerves were directed at right angles to their intermuscular space, and would have been infallibly fixed between the ends of the torn muscles in a dense mass of scar tissues, resulting in permanent loss of power of the member. In the seventh month after suture, *i. e.*, the usual period required for the degeneration and regeneration of a nerve, first sensation, and then motion returned, until now, although the functions of the member are not perfect, the boy can earn his living, and do nearly all that can be effected by a normal hand and forearm.

Further quotation of my own cases or those of other surgeons seems hardly necessary, and such good results as I here show you have been frequently reported.

Finally, how should the sutures be passed and what should their material be?

Fine aseptic catgut passed by means of an ordinary sewing needle is to be preferred, but fine aseptic silk can be used, and I myself have resorted to this in an emergency. Should the nerve be *very* much lacerated and frayed out, it may, perhaps, be sometimes proper to cut off a portion to gain a clean surface, but this is rarely desirable. The needle should be passed from below upward through the proximal end of the nerve at one border, across and then passed from above downward near the opposite border, entering the needle from an eighth to a quarter of an inch from the cut end, according to the size of the nerve. The needle must now be passed from below upward through the distal portion of the nerve at the border corresponding to the last passage of the needle through the proximal end, across, and made to pierce the nerve from above downward, when the suture will be found to correspond to the free end of the thread in the proximal piece of nerve.

Gentle traction with an appropriate position of the member will, by the tying of one knot, accurately approximate the nerve ends. In a word, by this simple method all the advantages of the two separate sutures commonly recommended are obtained with a far greater degree of security. I need not say that the strictest asepsis should be secured, which is easy enough, provided the wounded part, the surgeon's hands, and his instruments be strictly cleansed, and the wound be freely irrigated with the bichloride and tartaric acid solution. If the surgeon gets an uncontaminated wound, it is his own fault if he has suppuration, and even with the ordinary run of accidental wounds, if he will thoroughly scrub his hands with a nail-brush and hot water, and likewise so treat the parts surrounding the the wound, pour boiling water over his instruments, without any fur-

[1] In this patient the brachial artery was also torn through, leaving only a bridge of muscle and skin through which collateral circulation could be carried on. The deficient blood supply possibly explains the failure of the recovery of power in the interossei muscles, although other of the intrinsic muscles of the hand which are supplied by the ulnar nerve contract well.

ther antisepsis, in most cases healing without suppuration can be secured, while the omission of these details will mar results with gallons of mercuric solution flowing over the wound.

JABORANDI IN OBSTETRIC PRACTICE.

BY JEROME HARDCASTLE, M.D.,
CECILTON, MD.

Having for many years noted the fact that parturition does not progress favorably till *diaphoresis* occurs, I have for some months past induced this condition, in the early stage of labor by giving fl. ext. jaborandi (*green*—the brown has proved worthless in my hands). My plan is, when called to a case, to order a warm brick to be applied to the feet—which are always cold, and then to give one-third of a teaspoonful of fl. ext. jaborandi in half a wineglassful of water, and repeat the dose every half-hour until perspiration occurs. It is very seldom that more than two doses are required. The first effect of this medicine on the patient is soothing, she becomes more quiet, and bears her pains with resignation. Upon being questioned the patient often states that her pains do not hurt her as they did. On examination, after diaphoresis occurs, the os will be found dilating rapidly; the soft parts to be in a favorable condition; and in a short time the labor will be satisfactorily terminated. Should the patient appear weak from the sweating, I wipe her face and neck with a dry towel, and give her a teaspoonful of whiskey or half as much of aromatic spirits of ammonia.

Since using the above remedy, I have had no occasion to use ether, chloroform, or the forceps. I have not seen any mention of the use of jaborandi in obstetric practice; but, having had such favorable results from its employment I recommend it to the consideration of the profession.

—The *Engineering and Building Record* of March 3, 1888, says: The Directors of the Great Northern Railway have recently issued an order to their firemen and engine-drivers which should be the imitation of similar regulations throughout the various railways in the country. No fireman or engine-driver is to be allowed to go on duty unless he has had at least nine hours' rest. Such an instruction should not be necessary, but being necessary, its issuance is no less a boon to the men than a source of safety to the public.

SOCIETY REPORTS.

COLLEGE OF PHYSICIANS OF PHILADELPHIA.

Stated Meeting, March 7, 1888.

The PRESIDENT, S. WEIR MITCHELL, M.D., in the chair.

In opening the discussion on Dr. Ashhurst's paper[1] DR. WILLIAM HUNT said: Dr. Ashhurst has dwelt upon the importance of saving time. There is one way in which time might be saved, and that is by more than one surgeon operating at the same time. Dr. Morton and I have done that on two occasions, each taking a limb and operating at the same time. I do not know how it would work with three.

DR. H. C. WOOD said: I should like to make a remark with reference to this point of keeping up the animal heat. Many people die in acute disease, in acute poisoning, and after severe operations, because the temperature is not maintained. I have proven by experiment that if two animals are subjected to severe injury, and one is kept in a moderately cool room, and the other in a hot room, the one will die and the other recover. In this connection I will repeat a suggestion made to me by Dr. Dercum, which would afford one of the most efficient measures for maintaining temperature—and that is, to fill the ordinary water-bed with hot water, and allow the patient to lie on it.

DR. CARR, of Washington, said: I did not know until I heard the remarks of Dr. Ashhurst the importance of a case that I have had. I have performed a quadruple amputation for frost-bite. The patient was brought into the hospital in a condition of collapse with the four extremities frozen. He reacted well, and remained in the hospital a week, when his constitutional condition became serious, and after consultation it was decided that amputation of the four extremities was desirable. I operated, removing one foot above the ankle, the other foot through the metatarsal joint, one forearm about its middle, and one hand, leaving a small stump of the thumb, disarticulating it at the metacarpophalangeal articulation. The patient did very well.

In operating I secured the vessels with hæmostatic forceps, and left the stump in that condition while I proceeded to amputate another limb.

[1] See page 423.

Dr. J. William White said: I understood from Dr. Ashhurst's paper that in his classification of triple amputations partial amputations were not included. I had last year at the University Hospital a double knee-joint amputation, with amputation of a portion of one hand, leaving a thumb and one finger, and should have been glad to present the patient this evening.

In reference to the technique, I have only one or two suggestions to make. If the irrigation is done with warm or hot water, it does not necessarily reduce the temperature, and, in fact, may aid in keeping up the bodily heat. The same is true with reference to the use of wet towels, which can be rung out of hot water and frequently renewed. Bramann, assistant to von Bergmann, has recently detailed the results obtained at the latter's clinic by packing wounds with iodoform gauze. This prevents the formation of a blood-clot, which is, perhaps, next to a failure to secure asepsis, the most important cause of the failure to obtain primary union. Where there is danger of oozing, he packs the wound with iodoform gauze, which is allowed to remain from forty-eight to seventy-two hours. It is then removed and the sutures applied; in the vast majority of cases union by first intention is secured. Even when it was left *in situ* for from four to six days such union occurred after suturing. In a case of double or triple amputation time might be saved by packing the first operative wound with iodoform gauze as soon as the vessels are secured, and then dressing it. This could be done by an assistant, and the patient removed to the ward much sooner than if time were taken to introduce stitches. The suturing could be done any time during the next two or three days.

Dr. Mitchell said: I have listened with a great deal of pleasure to the remarks as to temperature of patients under ether or chloroform, and the possible influence of irrigation upon these cases.

I would like to ask what some of the gynecological operators would say. In their cases the abdomen is sometimes largely opened, and the intestines exposed; if irrigation lowers the temperature in ordinary surgical cases, how much more should it do so in these?

I think it would be advisable to have a series of experiments and observations as to the effects of ether, chloroform, and perhaps other anæsthetics, upon the temperature, when used for long periods. As concerns the interesting case of triple amputation shown us by Prof. Ashhurst, I would like to say that no physiological statement has been made, so far as I know, as to the effect of large losses of tissue upon the pulse, temperature, nutrition, blood-pressure, amount of urine, etc. A tempting subject here awaits some industrious observer.

Dr. White said: Experiments are now being made at the University of Pennsylvania, upon animals and clinical subjects, to determine the effect of the administration of ether on the bodily temperature, and seem clearly to indicate that a drop of from one to three degrees may be expected, not only in cases where no irrigation was used, but even where no operation of any sort has been performed.

The note of a case has just been handed to me, in which the temperature fell four degrees. The temperature before operation was 99.5°, and after operation (which was the removal of a tubercular testicle) it was 95.5°. No irrigation was employed. No general symptoms of shock, such as weakness or failure of the pulse, leakage of the skin, or shallowness of respiration, were observed in this case. A series of nine cases of all sorts of operations gave similar results, though the average reduction of temperature was not more than two or three degrees.

Dr. William Goodell said: In removing the ovaries, one has to be very cautious on account of the collapse that may occur if the ovary is pinched or roughly handled. Something similar, I fancy, would occur in the removal of the testicle, and this, I think, had a good deal to do with the fall of the temperature noted.

Dr. Ashhurst said: The suggestion made by Dr. Hunt is an old one. Before the days of anæsthesia it was thought that the patient might suffer less pain by having both operations done at once; but when the patient is insensible, there will certainly be less confusion by having only one done at a time.

With reference to irrigation, as I have already mentioned, I have seen the temperafall as low as 97° after a simple operation, and in operations not usually considered capital, such as the removal of the breast, the temperature has gone even lower, and the patient has remained in an extremely critical condition for hours. This has been where there has been no loss of blood, and no condition other than the irrigation to account for it. In cases where antiseptic measures have not been employed, I have not seen this depression, except when there has been great loss of blood, or unnecessary exposure of the patient.

In my list I have not included any but synchronous major operations. The cases

reported to-night seem to have been instances of minor amputation, as regards some of the parts removed, and can, therefore, technically be looked upon as only double, not triple, or quadruple amputations.

Another word with reference to irrigation; even if warm solutions be employed, they will tend to cool the body by evaporation, and the same is true with regard to wet towels; even if hot when applied, they will reduce the temperature unless covered with oiled silk to prevent evaporation. I do not think that the administration of ether alone has much effect upon the temperature, but under any circumstances we can better dispense with irrigation and wet towels than with anæsthetics.

In regard to the case of excision of the testis, which has been mentioned, it may be said that operations on the testicle necessarily require considerable exposure of the lower part of the abdomen. It is also a well-known fact, that division of the chord is often followed by profound shock. This observation has been made by Mr. Erichsen, at the University College Hospital, London, and my own experience confirms it. The moment that the chord is divided, the pulse fails decidedly, and there is more shock from removal of the testicle than from any other operation of equal gravity in the whole range of surgery.

I have no objections to the antiseptic method of treatment, and I am in the habit of employing it, but I think that we should not close our eyes to the fact that it may have some disadvantages. I think that the maintenance of the patient's temperature is of more importance than the exclusion of a few microbes. All that can be accomplished by irrigation can be equally accomplished by washing the part before and after the operation, care being taken to keep the patient warm and dry. The ordinary antiseptic dressings were employed in this case after the operations; I consider that their chief advantage is that they permit infrequent dressing of the wound.

NEW YORK ACADEMY OF MEDICINE.

Stated Meeting, March 15, 1888.

The President, A. Jacobi, M.D., in the chair.

Dr. F. R. Sturgis read a paper

On Some Questions in Connection with Syphilis Hereditaria Tarda.

It was only within the past twenty-five years, he said, that many diseased conditions had been ascribed to their true cause, namely, hereditary syphilis. The question which he wished to discuss was whether hereditary syphilis might lie dormant in the system, and first declare itself several years after birth. It was pretty generally acknowledged at the present day that if a patient presented himself to the surgeon with the advanced lesions of syphilis that the patient had had other and milder manifestations of the disease at some prior time. Surgeons went further and stated that the disease must have begun with an initial lesion, although no traces of it could be discovered.

Tables were given to show that in the majority of cases hereditary syphilis showed itself before the third month of life; but it was said that there were cases in which symptoms did not become manifest until later, and then the question arose, how much later?

Here Dr. Sturgis gave a brief account of cases reported by different observers who had asserted the occurrence of the first symptoms of hereditary syphilis at the twelfth to the twenty-seventh month, and in three cases from the twelfth to the fifteenth year. Comparing the histories of these cases with that of the usual history of hereditary syphilis, it would be seen that there was liability to mistake acquired syphilis for the hereditary form, and to overlook earlier symptoms of the latter disease. In the three cases quoted in which the symptoms of syphilis appeared at or after the twelfth year, Dr. Sturgis thought acquired syphilis could not be excluded. In the other cases early symptoms may have been mild, and therefore may have been overlooked. It was his own opinion that late symptoms of the hereditary form were always preceded by early symptoms, although the physician might be unable to draw out a history of the latter from the patient's relatives and friends. Sometimes it left the remains of an old keratitis, of mucous patches, etc.

Dr. E. L. Keyes thought late symptoms of hereditary syphilis were always preceded by early ones which had been overlooked or forgotten. Incidentally in the discussion he expressed the view that syphilis was a much more serious disease in children than in old people, because of the difference in soil; also that bichloride of mercury should be administered to young infants who had hereditary syphilis, say in one-fiftieth of a grain doses every two hours at first, and, as the symptoms began to yield, at longer intervals.

Dr. P. A. Morrow would be very much inclined to doubt whether any patient manifesting late evidences of hereditary syphilis had entirely escaped the early symptoms. He

had seen cases in which he had been unable to trace the history of early symptoms; but he did not regard that fact as at all conclusive that the early symptoms had not existed.

There was a disposition, he thought, to underrate the liability to lesions of hereditary syphilis after adolescence. We know patients might manifest acquired syphilis five or fifty years after taking it, yet hereditary syphilis was essentially the same disease.

Dr. R. W. Taylor said that while he looked upon hereditary syphilis as more erratic than the acquired variety, yet he was a firm believer that in the hereditary form there was always some manifestation in early infancy. If it could not be traced, it was because there were no remains of old lesions, want of persistence on the part of the surgeon in bringing out the history, or the ignorance of the patient and his friends.

Regarding lesions of hereditary syphilis after adolescence, he did not doubt but what they might occur, but he still claimed, as he had done in his chapter on this subject in Bumstead and Taylor's book, that after the twenty-first year it was extremely difficult to definitely exclude acquired syphilis, and unless strict precautions were enforced, physicians would be likely to attribute lesions to hereditary syphilis in many cases in which hereditary syphilis was not at all at fault.

Regarding the syphilis of old people being a light affair, as claimed by his friend Dr. Keyes, the statement was to him astonishing; for he had found that if there was ever a scourge to old people, it was syphilis.

Drs. L. B. Bangs, H. D. Chapin, A. S. Hunter, L. E. Holt, Goodwillie, and the President participated in the discussion. The general view was that late lesions of syphilis had been preceded by early ones, although the history might not be traceable.

SECTION IN PRACTICE.

Stated Meeting, March 20, 1888.

R. C. M. Page, M.D., Chairman.

Dr. J. West Roosevelt read a paper on

Pernicious Anæmia: Certain Questions Suggested by Cases and Autopsies.

From the study of certain cases of pernicious anæmia which had come under his observation and of reported cases he had been led to the following conclusions: (1) That in some cases of pernicious anæmia there is found a lesion of some important organs which, in certain cases, may have produced the blood disease. (2) That after these cases, together with those which seem to be caused by parasites and those which follow hemorrhage have been excluded, there remain some in which the blood lesion seems to be primary.

The first case related was that of a girl 20 years old, who had indulged in a peculiar and bad diet, and had taken much tea. She was at the age when simple anæmia is common. For a year she had menstruated irregularly, but she dated the real beginning of her illness from the period at which menstruation ceased, four months before admission to the hospital. Two months before admission she observed that she was paler than before, and she had occasional œdema of the feet. She did not seem to have been ill, however, until after an attack of jaundice one month before Dr. Roosevelt saw her. Following this and two similar attacks the graver symptoms appeared. Although she had temporary improvements she finally died, having presented the usual symptoms of pernicious anæmia. Dr. Roosevelt thought it might be assumed from the autopsy that the jaundice was the result of inflammation of the bile ducts produced by calculi found in the gall bladder. According to the patient's own statement the disease terminated fatally about eight months after its onset. As menstruation had been irregular for a year it was probable she had suffered from anæmia at least that long before admission. Taking into account the patient's age and her diet he thought it possible that the disorder began as a simple anæmia, and that the attack of jaundice still further increased the anæmia. As a result of the jaundice the blood-forming organs were taxed beyond their powers. Jaundice had been noted in several cases of pernicious anæmia.

The second case gave a very different history. There had been chronic gastritis extending over six months at least. Emaciation was a prominent symptom. The only apparent reason for the anæmia, besides the stomach lesion, was the occurrence of severe bleeding from piles thirteen years before the patient's admission. In spite of the emaciation the case resembled very closely pernicious anæmia. The autopsy showed the lesions of chronic gastritis. There was a question whether chronic diffuse nephritis was present, but the author was disposed to think the kidney changes were those of natural increase of fibrous tissue found usually in patients of her age. Of the relations between the stomach lesion and the symptoms this much alone could be said, that many patients lived a good while and pretty com-

fortably with a stomach as bad as this one. When this patient became very ill she presented symptoms like those produced by malignant disease. These symptoms were rationally explained by the blood state. It is possible that the blood state was secondary to the stomach lesion, but we would have to admit, for the production of pernicious anæmia as the result of gastritis, the necessity either of independent disease of the blood forming organs, or that as the result of the stomach lesion such a change took place in the gastric ferments as to lead to the production of poisonous digestive products instead of normal peptones. Evidence that the stomach and blood lesion were both the result of the same cause is wanting. It is interesting to note that in a number of reported cases symptoms of dyspepsia had preceded the anæmia.

In a third case of which the author gave a detailed history there was a condition of pernicious anæmia complicating Bright's disease. The patient died thirty-one days from the commencement of his blood lesions and hemorrhages from the rectum and mouth. Of course, said the author, the occurrence of symptoms of pernicious anæmia during the course of Bright's disease is well known. The blood had not yet been sufficiently often examined, but the patients seem to suffer from the same symptoms as those of pernicious anæmia, and in this case the blood lesions were typical.

Dr. Roosevelt gave a brief general description of pernicious anæmia. The onset was usually gradual. Pallor was frequently the first symptom noted, and when the disease had become fairly developed it was frequently rather characteristic; the skin had a yellow, lustreless, white tint. Dyspnœa, cardiac palpitation, headache and symptoms of increasing weakness developed; sooner or later an irregular fever set in; there might be some dropsy; patients usually retained their fat, or it might increase; hemorrhage from various mucous membranes occurred in some cases; hemorrhage into the retina and chorid was almost invariably present. The red blood discs and hæmoglobin were below the normal; the reduction might reach one-sixth or one-seventh the normal. The white blood cells were nearly normal in number. The red cells showed changes in size and shape, and it was said nucleated discs sometimes appeared.

In some cases death took place in a few weeks or months; in others, not for years. Temporary improvement followed by relapses was often seen. The diagnosis from simple anæmia was difficult, and sometimes perhaps impossible. There seemed to be no symptom nor group of symptoms found in the grave disease which were not found in the milder type. Of course, if by pernicious anæmia we meant necessarily fatal anæmia, we might wait until death or recovery cleared up the diagnosis. The resemblance of these cases to Addison's disease was quite marked, but in the latter disorder anæmia was not a necessary symptom. Whether or not it was closely related to Hodgkins' disease and to leucocythæmia is not yet quite settled. Clinically, Hodgkins' disease is differentiated by the lymphatic, splenic, or hepatic enlargements, while the excess of white cells distinguishes leucocythæmia from the others. As to lesions, the blood during life is paler and thinner than normal. The red discs are much diminished in number, perhaps fifteen or twenty per cent. of the usual number could be found. The discs are more or less altered in size and shape; the white cells relatively, but probably not absolutely, increased in number. In other organs the most common lesions seem to be fatty degeneration of the heart, liver and kidneys; similar degeneration of the great vessels had been found. Hemorrhagic extravasation into the retina and chorid is almost constantly found. Together with some optic neuro-retinitis, extravasations of blood elsewhere may occur. Inflammatory changes in any of the organs may occur as an incident of the disease. The serous cavities often contain an excess of blood. Gastric lesions, chronic diffuse nephritis, lesions of the pancreas, fatty changes in the liver, etc., have been described. Intestinal parasites are sometimes seen. The body is usually fat; the muscles and all the organs pale; the fat is often of a peculiar yellow.

The etiology is not clear. If overwork, bad food, foul air, pregnancy, gastritis, etc., etc., are, as has been suggested, causes of pernicious anæmia, the disorder should be very common instead of very rare.

Looking at pernicious anæmia as he had defined it, making the definition broader than many would admit, might we not say, he concludes:

1. That a condition with similar course and symptoms had been observed in cases with precedent grave stomach, kidney and liver lesions?

2. That in these cases, however, the condition was so rare as to make it difficult to suppose that under ordinary conditions the blood state could be the direct result of them?

3. That in all cases in which there had

been any other tangible cause this had hardly been sufficient of itself to produce the disorder? There was too much gastritis, Bright's disease and misery seen without such effect. The same was true of every other cause.

4. Let there be congenital or acquired weakness of blood forming organs and then, as various authors had suggested, it would be conceivable that by a "vicious circle" the condition might result.

5. That after all known possible causes had been excluded certain cases still remained.

Finally, he would direct attention to the fact that in many cases, whatever be the supposed cause, there was a history of long-continued gastro-intestinal disturbance before the onset of the pernicious symptoms. In view of this, was it not possible that some of the cases were the result of poisoning by substances produced in the gastro-intestinal tract? If there was such a possibility, should not efforts be directed toward clearing out this tract in all primary cases?

PHILADELPHIA COUNTY MEDICAL SOCIETY.

Stated Meeting, March 14, 1888.

The Vice-President, W. W. Keen, M.D., in the Chair.

In opening the discussion on Dr. Nancrede's paper, on the

Importance of Primary Suture of Divided Nerves, with an Illustrative Case of Suture of the Median and Ulnar Nerve,[1]

Dr. H. R. Wharton said: I have seen one or two cases of primary nerve-suture, though none in which the injuries were so extensive as in this interesting case of Dr. Nancrede's. The results in these cases were good. There is another point to be considered. Shall we attempt secondary suture of the nerves when this has been omitted in the first place? I am very decidedly of the opinion that this procedure should be adopted, for a number of cases have been reported of this character, in which the results have been at least good suture enough to make me feel that secondary should be attempted when there is any probability of restoration of the use of the injured part. I thoroughly agree with Dr. Nancrede as to the great importance of this subject.

Dr. John B. Roberts: The only case of nerve-suture I remember at present is one in my wards, in which the work had very properly been done by the resident immediately on the admission of the patient. It was a rather extensive incised wound of the leg, involving, I think, the musculo-cutaneous and anterior tibial nerves. The muscles and nerves were sutured and dressed antiseptically, and the results were good; though I did not follow the case after discharge so as to make an accurate report as to sensation. Dr. Nancrede has incidentally touched upon a point of great importance, that of teno-suture. It has been my misfortune to meet with quite a number of cases in which this had been neglected by the attendant called at the time of the accident. One of these recently seen was that of a man wounded in the forearm just above the wrist, and in the ring finger. There was loss of flexion of the finger, but it was hard to tell which of the wounds to reopen in order to come upon and suture the divided tendon. The family physician believed it to be the wrist; but after cutting down, I found the tendon here flaccid and intact. I then opened the finger-wound, and here found the tendon retracted into the sheath. I sutured, but did not get a good result, probably from the extent of dissection necessary to get at the tendon in the sheath, and the great mass of cicatricial tissue. However, I never hesitate to reopen healed or partially healed wounds to suture tendons when this very important measure has been neglected.

I have been glad to hear Dr. Nancrede say that with cleanliness of person and of instruments asepsis can be secured without chemical solutions. This is in marked contrast to one of my friends, a surgeon of prominence, who thinks that the employment of solutions renders care as to cleanliness unnecessary.

Dr. J. William White: I do not know whether Dr. Nancrede spoke of the resection of the crushed and bruised ends of the nerves or not. The general principles of nerve-suture are admitted by all surgeons, but the question of resecting lacerated or contused ends before suturing, or of allowing them to remain, is one that should be carefully considered in each case. On the one hand, by resection of any considerable portion we increase longitudinal tension, and make greater strain on the sutures; on the other, we run the risk of including in the stitches tissue too much damaged to recover itself. There is some difference of opinion as to the particular suture to be employed. I should think that the one proposed by Dr. Nancrede, as shown in his diagram, would be open to objection, if, as there apparently repre-

[1] See page 429.

sented, it interposes a foreign substances, the catgut thread, between the ends of the nerve; this, if not absorbed, as is sometimes the case even with the best catgut, is liable to be a constant source of irritation, and to prevent union. I prefer and employ a suture passing quite through the nerve above and below the point of union. Evidence, either clinical, or pathological, or experimental, as to the relative advantages of different sutures is desirable, but I do not know of any, and I did not understand Dr. Nancrede to say that there was such evidence.

The CHAIRMAN, DR. W. W. KEEN: There are two case I may briefly cite from my own experience in connection with the subject of our discussion:

1. A case of primary nerve-suture in a boy two years of age, with perfect recovery of motion and sensation. The case occurred ten years ago. The child, carrying a glass bottle, fell, and a fragment of glass divided the ulnar nerve and artery about an inch and a half above the wrist. The mother made compression with her thumb until I arrived, very soon after the accident. After ligaturing the artery, I examined the nerve and found that it had been divided. I had only my pocket-case containing coarse white silk and an ordinary needle. Not wishing to leave the coarse silk in the wound, particularly not in the nerve tissues, I debated as to the method of suture, and devised one which proved eminently satisfactory. Drawing the ends together closely with forceps, I passed a surgical pin obliquely through the two divisions, threw a loop of silk around the point of the pin (as in Simpson's method of acupressure), drew out the thread, passed it around the head of the pin, where it was secured. At the end of forty-eight hours the pin was removed. The thread was thus loosened and removed. Perfect union of the wound took place in a few days. There was no wasting of muscles, and motion was present after twenty-four hours. While the age of the child prevented exact observation as to the time at which sensation returned, at the end of forty-eight hours there was an exclamation of pain on pricking the little finger with a pin. I saw the father of the boy about a year ago, who told me that his son had perfect use of hand and fingers.

2. Extensive teno-suture, with quick union. A recent case shows the value of even a brief suture of tendons. A man twenty-five years of age was admitted into St. Mary's Hospital with complete severance of all the tendons of the forearm and of the sheath above the wrist. The resident sewed each tendon carefully. He had only Kocher catgut, which does not remain more than three to five days, and then closed the external wound and placed the hand in flexion on a splint. The man left without permission after a few days, and it seems removed the splint and tore out the sutures in the skin. He returned later with a gaping wound in the forearm, but on testing the fingers separately each finger and each joint was found to have perfect motion, showing that even this temporary apposition of the divided tendons had a perfect result. I should prefer for the purpose, however, either very fine silk, or, better, the ordinary chromicized catgut.

DR. NANCREDE: Dr. White has misunderstood me. There is nothing between the divided ends of the nerve. If he will examine the rough model which I pass around he will see that the nerve is securely and accurately coaptated by the suture. I have no distinct recollection of resecting the injured ends in this case, in fact, I am nearly certain that I did not. In some cases I have said it *might* be desirable, but I am dubious about it. In two other cases that I recall at this moment, I remember that I did not make any attempt of the kind, but brought the ends together as best I could. Referring to the incidental discussion, I am glad to hear that so many of our members always suture tendons. I make it a rule to suture nerves and tendons in every case, and generally obtain fair results.

DR. HOWARD F. HANSELL presented a patient with

Ectopia Lentis.

Clarence P., aged ten. This colored boy presents several deformities: A peculiar shape of head, deviation of spine, anterior curve of each tibia, and is more or less undeveloped. I have asked him to present himself before the Society in order that those members who may be interested may have the opportunity to see a case of "ectopia lentis," congenital upward displacement of each lens. The margins of the clear lenses may be distinctly seen about the centre of each pupil. The right lens is dislocated upward. The left, upward and outward. Each eye is highly myopic—*i. e.*, as seen through the lens, and hypermetropic as seen under the lens. The temporal side of each nerve shows a large patch of atrophic choroid—post-staphyloma. There is no coloboma of the iris or choroid. With the right eye the boy can read large print only when held two and a half inches from the eye in an upward and outward position. The left eye is useless.

Reports of Clinics.

HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA.

SURGICAL CLINIC—PROF. ASHHURST.

Triple Amputation.—Recovery.[1]

The first patient is a young man, a Moor, who is almost ready to be discharged from the wards. He has been the subject of a triple amputation, rendered necessary by injuries which he received in a railroad accident. His right forearm and right leg were hopelessly crushed, and the left leg was completely torn off an inch or two above the ankle. When brought here he was, of course, in a state of shock, but as soon as sufficient reaction had been secured to render it permissible, the operation was begun. The site of the first amputation was through the lower third of the right thigh, the second through the middle third of the left leg, and the third just below the wrist of the right side. All three stumps are now completely closed, and the patient's condition is excellent. In addition to the injuries of his extremities which required amputation, there was a compound fracture of the skull (the frontal bone), without, however, much depression. There were several severe contused wounds of the scalp, and a number of others distributed over the remaining portions of the body, some of which gave rise to deep and extensive sloughs. Recoveries after such severe injuries as we have had here, are very rare. Success, I believe, depends not so much upon the care and skill displayed by the surgeon in operating, as upon the constitutional vigor and healthy condition of the patient. I have had but one other case of triple amputation; and, although the man lived for ten days following the operation, he finally succumbed to exhaustion, due, unquestionably, to visceral disease resulting from alcoholic excesses. This young man doubtless owes his life to his youth and healthy condition, and to his temperate mode of life before his accident.

In cases like this, were there is grave injury, I invariably begin the use of carbonate of ammonium immediately upon the completion of the operation. Depending upon the age and condition of the patient, I order from two to five grains every two hours or oftener. This drug serves a double purpose—it not only is a powerful and prompt cardiac stimulant, but it acts, also, by maintaining the fluidity of the blood and so diminishing the tendency to the formation of heart clot. This is the condition present in the cases which received from the older surgeons the name of "secondary shock." It may cause death by gradual failure of the circulation, or it may kill suddenly by embolism. It may be necessary, of course, to combine with the ammonia such other stimulants as whiskey and digitalis, and the bodily temperature must be maintained by the application of hot-water bags, etc.

[1] See page 423.

Resection of Inferior Dental Nerve for Neuralgia.

This woman, past middle age, has suffered during the last four years from neuralgia of the lower jaw. In search of relief, she has had on different occasions, several teeth removed, but when the last one was extracted, her suffering, instead of being lessened, was aggravated.

We find that the pain follows the course of the inferior dental nerve. This, you are aware, is a branch of the inferior maxillary division of the fifth nerve. It enters the lower maxilla at the dental foramen, passes downwards and forwards in the dental canal beneath the teeth, emerges at the mental foramen, and distributes its terminal filaments to the chin and lower lip. Many different remedies and plans of treatment have been tried in the endeavor to afford relief to this patient, but all have proved futile. There can be no impropriety, therefore, in resorting to excision of a portion of the painful nerve.

Neurotomy, or simple division of a nerve, is not to be recommended, because prompt reunion would be almost certain to follow, and so render the operation useless. Resection, or neurectomy, is necessary, and a considerable portion of the length of the nerve should be removed, the object being to delay reunion as long as possible or prevent it altogether.

The nerve can be readily reached at its point of entrance to the canal. A semi-circular flap is raised from over the angle of the jaw, and the outer wall of the dental canal removed with a small trephine. The exposed nerve-trunk is now raised from its bed and about three-quarters of an inch of its length is removed. I will control the bleeding from the artery in the canal by introducing a plug of catgut.[1]

Gelatinous Arthritis—Excision of Knee-joint.

This patient is 45 years of age. His left knee began troubling him more than five months ago. The joint now, as you see, is

[1] The patient did well after the operation, the neuralgic pain being instantly relieved.

much swollen, the leg is somewhat flexed upon the thigh, and we find on palpation that the swelling has a doughy, semi-fluctuating feel. There is already some dislocation of the tibia; the ligaments are relaxed, and permit an abnormal degree of lateral motion. From the fact that motion of the joint is productive of severe pain, we are led to suspect the involvement in the disease of the layer of bone immediately beneath the articular cartilage.

I need scarcely tell you that this is an example of that variety of joint disease, called gelatinous arthritis. In this form the synovial membrane is found in a pulpy or gelatinous condition, which almost invariably leads to destructive disorganization of the joint. As the disease progresses, the articular cartilages undergo an analogous change, and it finally reaches the bones, which become softened and carious. The symptoms of this peculiar form of disease, appropriately called "gelatinous arthritis," and which is rarely seen except in the knee and elbow, differ from those of ordinary arthritis in several particulars. The swelling is more diffused, and attended with comparatively slight fluctuation, being of a doughy and somewhat elastic type. The pain is not very well marked, and in the early stages is of a dull character, differing both from the acute pain of ordinary synovitis and from the jumping pain which attends exposure of the bone by ulcerating cartilage. There is little or no heat, and should the part be at first red, the surface soon looses its color, often becoming at last positively blanched—an appearance so characteristic as almost to justify the name of *white swelling*, formerly given to these cases. Another diagnostic point is the mobility of the joint, which often remains even when the disease has reached an advanced stage. In the instance before us the morbid process has progressed so far that spontaneous cure cannot be hoped for, and removal of the joint becomes imperative. The question, therefore, lies between excison and amputation, and, in chosing between these two operations, preference should always be given to excision, provided that the circumstances of the particular case admit of a choice. In this case the circumstances opposed to this operation are the man's age and the extensive implication in the disease of the bones and surrounding tissues. Either extreme of life is considered unfavorable to excision on account of the long period requisite for recovery after the operation. If the soft tissues around a diseased bone or joint be extensively implicated, the result of an excision is less apt to be satisfactory than when this is not the case, though the operation is not absolutely contra-indicated by such a condition.

This patient has left the final decision of the operation to be performed to me, and I shall begin, therefore, as though I contemplated excision only; but if, on thorough exploration, I find that disorganization has progressed so far as to render the success of this operation doubtful, I shall resort to amputation. Excision of the knee-joint may be performed in several ways, but those of most common adoption are by the H, the U, and the simple transverse incision. The last is, in my judgment, the best, and is the one I shall select here. [After opening the joint cavity and subjecting it to a careful examination, the operator felt justified in attempting to save the limb by excising the diseased structures. The patient did well after the operation, the wound rapidly healing.]

Foreign Correspondence.

NEWS FROM PARIS.

Académie de Médecine.

A number of corresponding members now in Paris for the Congress of Surgery were at the last meeting of the Académie. M. Koegel, of Strasburg, read a note upon arthrectomy as practiced by him for gangrene of the knee. The process by which M. Koegel has obtained such good results consists in opening the joint, cleaning out the synovial cavity and the tendons or bones attacked by gangrene, and after applying appropriate remedies, making the limbs immovable for some time by means of a salicylate of soda cast. The disease should, however, be treated immediately on its appearance.

M. Queirel, of Marseilles, had employed antipyrine in hypodermic injections, and with women, as an anæsthetic, to diminish or overcome altogether the pains of labor. This remedy gave great success in these cases.

M. Doyen, of Rheims, made known the result of his researches as to the relation existing between the three microbes, those of puerperal fever, erysipelas, and purulent infection. He is inclined to think that the different manifestations produced by these microbes depend principally on their age and development. They undergo evolutions which make it difficult to decide whether they belong to a single or to several species. These observations, taken with those which M. Bouchard recently gave to the Académie, tend to confirm the

opinion that the idea which supposes the species of the microbes depend upon their form, is an error. The same microbe may be found under all the known forms. That is to say, in infectious diseases, these elements, though able to propagate infection and act as a means of carrying poison, are only the agents of the cause of disease, and not the cause itself. They may become the cause, but only in a secondary way, by carrying the disease from one subject to another.

French Congress of Surgeons.

The third congress of surgeons in France has opened. In his inaugural address, Professor Verneuil dwelt on all that surgery in France had accomplished up to date, and he drew a parallel between the attacks of Dr. Billroth, the German surgeon, and the praises bestowed on the efforts and results of French surgery in all the works of the learned societies in every part of the world. M. Verneuil thus spoke: "Dr. Billroth, after most violently attacking, with evident incompetence, our illustrious Pasteur, deliberately and without any reason reproaches French surgery for not keeping pace with the immense progress in surgical science made in Germany and England. I admit that we can, and that we should, learn something of our rivals, but I contend that it should be on a footing of reciprocity. I do not think we have far to go to find, in the esteem of our foreign friends, ample compensation for Dr. Billroth's attacks; in my opinion, no one is less capable than our eminent colleague of appreciating the value of French surgery, for the simple reason that no one is more ignorant of it than himself. If proofs in support of my statement were wanting, I would point out that I seek with you in vain, in the tenth edition of Dr. Billroth's *General Pathology* as in its first, for the slightest mention of the best French labors." After reviewing all that has been accomplished since the last congress, Dr. Verneuil concluded as follows: "Let us give unreserved praise, gentlemen, to the popularization of surgery, so much in keeping with the humanitarian and disinterested spirit of our race. The spread of surgical research in a democratic spirit, without detracting from the merits of the great, will widen the opportunities of the more humble; and the time is not far distant, when enlightened minds, and skillful hands, will be found in the remotest corners of our land. If the French Surgical Congress is enabled to hasten so happy an event, then it will have deserved well of Science and of our Fatherland."

M. Ollier, of Lyons, treated cases of *Ankylosis of the Wrist by Resection*, which left full mobility of the wrist, while at the same time preserving its radial and cubital motor tendons, which were formerly sacrificed. The antiseptic arrangements adopted enabled the operations to be performed without danger. The first case operated on by Dr. Ollier, was that of a young woman, already suffering from a compound osseous ankylosis of the elbow. In this case he resected the carpus and a centimetre of the bones of the forearm, and enabled her to perform on the piano.

Concerning *Ablation of the Larynx*, Dr. Demons, of Bordeaux, says he has successfully performed the operation in the following manner: "I first of all made a transverse hypohyoidian incision, from the middle of which I carried a transverse incision down to a little above the wound left by tracheotomy. I then effected the vertical incision of the thyroid cartilage; a step of the greatest importance, as it enabled me to ascertain that the left side was affected. I consequently determined on total ablation, which was effected, leaving only the cricoid, which I leveled by merely extracting the upper part of its amentum. The operation lasted three-quarters of an hour, and was most successful, thanks to the Trendelenburg canula, to which I superadded an iodoform pad. The after-treatment was of the simplest."

Dr. Dupont, of Lausanne, stated that the danger in the foregoing operation lay in the admission of blood into the respiratory passages. This is obviated by the use of Trendelenburg's canula; the serious inconvenience of this instrument, however, is that a fit of coughing suffices to expel it. Dr. Dupont said he obtained the same result, in a simpler and safer manner, by separating the trachea from the œsophagus, and folding it down forward in the lower angle of the wound, and there fixing it by a suture. This new direction removes it from the axis of the lower extremity of the larynx; and, therefore, the blood flows back of it.

In the operation of ablation, Dr. Molliere, of Lyons, excised one-third of the posterior part of the larynx, and a great part of one of the vocal chords, which he afterwards sought to reconstitute by suture. He completed the operation by a suture of the epiglottis to the cutaneous wound, in order to prevent the passage of food into the larynx. Molliere is in accord with Dr. Demous in recommending his method of operation for well-defined cancer.

The conclusion to be drawn from a long discussion between Drs. Chauvel, Delorme,

Poncet, Reclus, Trélat, Labbé, Nimier, Verchère, Chavasse and Castex, that in gunshot *Wounds of the Intestine*, immediate action of the surgeon offers great chances of success; but that the conveyance of a wounded person, for even a short distance, seldom leaves any hope of averting danger.

Periscope.

The Vaginal Tampon and Its Use.

In an address before the Alumni Association of the Woman's Hospital, Dr. T. A. Emmet spoke of the use of the vaginal tampon in the treatment of certain effects following pelvic inflammations. In the course of his remarks, (*N. Y. Med. Journal*, February 18, 1888) he stated that hot water is invaluable in the treatment of all stages of inflammation involving the cellular or connective tissue of the pelvis, in lymphangitis, in phlebitis, and in the early stages of pelvic peritonitis. On the other hand, he thinks that the vaginal tampon has only been beneficial after all acute symptoms have subsided. If this one feature is not recognized as a cardinal point, the indiscriminate use of this means of treatment will always be attended by unsatisfactory results, and with much unnecessary suffering to the patient. The only cases in the treatment of which he has derived any special benefit from the use of the vaginal tampon have been those in which he has supposed the blood-vessels had degenerated into a varicose condition, and where this state of the veins has been brought about from the effects of local peritonitis with adhesions, from the loss of the connective tissue, and from injury where the fascia has been involved.

In using the tampon we must trust, he says, to the use of the thermometer to show the absence of an elevated temperature in the pelvis, and to the want of other symptoms indicative of existing inflammation. In the absence of other symptoms we must exclude to a great extent the presence of pain on pressure as an evidence of active inflammation, its chief value then being but an indication of the manner in which the tampon should be applied. He holds that the tampon acts mechanically, by compressing the dilated veins and by lifting the uterus to its natural position in the pelvis, so that the circulation between the arteries and veins may be equalized. He has found that by repeated trials that the best material for tampons is the cleanest quality of cotton wool as sold in the shops and put up in rolls. In preparing it he takes a number of pieces of cotton of about the width and thickness of four fingers. He then makes a ball of each by turning the four corners or edges together, and while grasping these he thoroughly smears the outer surface with vaseline. Each ball is then of about the size of an English walnut and keeps it shape as it is packed loosely into a tin box for use. It was found advisable to have these balls of cotton as nearly uniform as possible and of about the size indicated.

On beginning the operation it is sometimes necessary to place the patient on the knees and chest before the uterus can be replaced. Then several balls are to be introduced and placed at a point where the uterus can be held by means of the finger while the patient is turning upon her back. One ball of cotton after another should be placed in the vagina and passed closely along the index finger of the other hand, which is engaged in pressing back the perineum and in holding up the uterus, or that portion of the tampon already introduced.

If one part of the vagina is more sensitive than another we must learn, he says, to "humor" it, by making less direct pressure until tolerance becomes established. When the sensitiveness is situated in the neighborhood of one of the broad ligaments we must pack the cotton on the opposite side of the cervix to act as a crutch. If the inflammation is chiefly about the utero-sacral ligaments, it is easy to tampon so that the uterus will be lifted without making direct pressure. The tampon should be placed so as to make as little direct pressure to the left as possible along the course of the rectum. After the introduction of a sufficient amount of cotton we are to pass the index finger carefully over every portion, to be certain that it is uniformly placed and to smooth down the entire surface. When this "finishing off" is properly done it is possible, from the coherency of the cotton and vaseline, to pack but a portion of the vagina. It may be but the upper part, or to one side, and it is likely to remain in position.

"There are two practical points in the application which, if not carried out carefully, will cause all our efforts to miscarry. The first is to keep the uterus, throughout the whole course of treatment, as nearly as possible in its natural position and at the same plane in the pelvis. The other is to place the fresh tampon without delay after the other has been removed. I have been in the habit of renewing the tampon daily for the patients in my private hospital. But if it could be kept deodorized, the longer it remained undisturbed the more thoroughly

would both of these indications be met in practice."

"The best instrument for removing the cotton is a piece of whalebone with a rough screw cut in the end, a simple device for the application of which we are indebted to the late Dr. Sims. This is easily passed alongside of the finger and twisted into one portion after another. It is well to leave that part directly under the uterus until the last, so that the finger may be slipped beneath the cervix, at the proper moment, to hold it in place until the fresh tampon can be introduced. To facilitate this, everything should be prepared beforehand. It is very evident if the uterus is allowed to prolapse, that just in proportion as it does so the circulation must be disturbed, and that if there is any advantage to be gained from maintaining a steady and uniform pressure, it must be, as nearly as possible, a continuous one. Therefore there should be no unnecessary delay in returning the tampon, as the blood begins again to rapidly dilate the vessels as soon as the pressure is removed."

A serious drawback to the satisfactory progress to be gained by this mode of treatment, says Dr. Emmet, is the recurrence of the menstrual period, when the use of the tampon has to be discontinued. To obviate this, just before the period is expected he removes the tampon and immediately introduces one of the rubber rings of a sufficient size to admit of the introduction of the finger between it and the vaginal wall at any point. These rings are about three-quarters of an inch in diameter, and so long as the patient remains in the recumbent position their broad surface offers a fair substitute for the tampon both in exerting a direct pressure upon the larger vessels and by taking up the slack in pelvic tissues. As soon as the flow has ceased he has a large hot water vaginal injection administered and then employs the tampon as before in the continued treatment of the case.

Traumatic Aneurism of the Orbit.

In the *Bristol Medico-Chirurgical Journal*, December, 1887, A. W. Prichard reports the case of a boy ten years old who was looking through a key-hole on May 23, and while in this position had a piece of umbrella wire thrust into his eye by a boy on the other side of the door. The wire probably penetrated deep into the orbit by the inner side of the eye-ball. A small wound on the conjunctiva and some blood under it towards the inner side, were the most noticeable signs of the injury. A few hours afterwards there was considerable ecchymosis; the globe was almost fixed, moving from side to side only about one-eighth of an inch; this was the cause of double vision; but with that exception, the sight of the injured eye was unaffected. During the first fortnight the ecchymosis was the only symptom; both lids were very dark and the ocular conjunctiva had blood under it. The boy complained very little, and a cold pad was kept generally over the eye. By June 9, however, there was some protrusion noticed, and a faint pulsation could be felt on putting the hand over the eye-ball. On listening with a stethoscope on the eye, a loud bruit could be heard; this was audible all over that side, and faintly over the other side of the cranium. Moreover, the boy complained of a blowing sound in the left ear. Thinking the case was one of traumatic anuerism—or possible of a blood-tumor pressing on the carotid artery, the author for three weeks tried the effect of continuous pressure on the eye-ball with ice around the orbit. This had the effect of ameliorating the diplopia, but accurate measurement from the forehead proved that the protrusion of the globe was increasing.

By July 4 the protrusion had increased so that the injured eye was as much as $\frac{1}{16}$ of an inch in front of the other. There was considerable chemosis and blueness all round the orbit; the bruit was very marked, and pressure on the left carotid entirely stopped it; the boy had headaches and restless nights. Accordingly, after consultation, on July 5, he tied the common carotid on that side at the level of the cricoid cartilage. There was no great difficulty in the operation; the vein was large, and as it were enveloping the artery, and it had to be held carefully out of the way. The vessel was tied with medium-sized catgut, and a small drainage tube put in the wound; the operation was done without a spray. In the evening after the operation no bruit could be heard and no pulsation felt, and the eyeball had receded $\frac{1}{8}$ of an inch. During the next week the boy went on very well. The wound healed very kindly and the eye receded; the double vision was less, and the chemosis and swelling of tissues round the orbit went down. He remained in the infirmary for six weeks after, and to the author's disappointment the bruit returned, and was heard as early as one week after the operation. It was not nearly as loud, however, and was inaudible to the patient himself. The eyeball receded as gradually as it had come forward, and when the patient went out the protrusion only amounted to $\frac{3}{16}$ of an inch. The diplopia was still present, but in other respects the boy was well.

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THE TREATMENT OF INEVITABLE MISCARRIAGE.

Some authors divide the premature expulsion of the ovum into abortion, miscarriage and premature labor. While this is a purely arbitrary classification, it has the advantage of calling attention to the fact, that in general terms the immature ovum is cast off by one of three methods. First, the ovum is cast off entire, the decidua sometimes accompanying, and sometimes following it. Second, the membranes rupture, the fœtus is discharged, and the secundines follow with difficulty. Third, the conditions are analogous to those at term.

During the first two months, when the ovular attachments are slight, the ovum is usually expelled *en masse*, without difficulty, the decidua subsequently coming away in shreds or as an entire membrane. The physician is seldom called on to treat these cases, as the patient is apt to consider the hemorrhage as a delayed and somewhat difficult menstruation. The ovum is usually passed in enveloping clots, and frequently escapes attention. Sometimes the ovum, as well as the decidua, is discharged as detritus. The dangers here, as in all cases of miscarriage, are two—hemorrhage and sepsis. At this early time these are slight. Should serious hemorrhage occur and continue after the use of ergot and the tampon, the case should be treated like one of obstinate bleeding from the non-pregnant uterus, the cavity should be gently curetted with Thomas's curette, and either mopped dry with cotton on an applicator, or irrigated, and have Churchill's tincture of iodine thoroughly applied to its cavity. This application is not caustic, and it is both hæmostatic and antiseptic. Before the third month sepsis is hardly to be feared; it could scarcely be present except by direct infection from the examining finger of the attendant. If present, its treatment would not differ from that of the later months.

Frequently during the third month, more rarely afterward, the ovum is expelled entire. In this form of delivery the hemorrhage is slight, owing to the intra-uterine pressure of the intact ovum. Hence, if on making touch during the third and fourth months the elastic amniotic sac is felt, great care should be taken to avoid rupturing it. Should the ovum be found in the vagina or hanging free in the cervix, it should, of course, be removed. But detachment is a *sine qua non*. Before detachment, officious effort may rupture the membranes and add the greater dangers and difficulties of that form of delivery. Unless the patient be unusually distant from the attendant, with ordinary contraction no treatment is called for. But as the membranes are liable to rupture without warning, and hemorrhage to ensue, under peculiar circumstances a tampon may be introduced as a matter of precaution. Nevertheless, where the physician can visit the patient with reasonable frequency, it should not be used in this class of cases. It needlessly complicates the treatment, and unless strict antiseptic precautions be taken, it increases the liability to septicæmia. Besides, it adds to the discomfort of the patient. Where the process of expulsion is slow, it may be hastened by moderate doses of ergot, a half drachm of the fluid extract every third or fourth hour. The

Faradic current is also recommended to increase the force of the contractions (Grandin). A weak current should be used, one pole being held by the patient, the other passed over the hypgastrium. I have not used the method. The tampon may be used in tedious miscarriage, not for its hæmostatic powers, but for its reflex effect upon the uterine contractions.

When rupture of the membranes occurs, either from criminal operative measures, uterine contractions, or the manipulations of the attendant, two complications are apt to ensue: active hemorrhage, and retention of the secundines. With the collapse of the membranes intra-uterine pressure is reduced, and the ovum no longer acts as a natural tampon—hence the bleeding. The uterus also acts at a disadvantage, thus increasing the liability to retention. It is here that the tampon finds its strongest indication. It should be reinforced by the administration of ergot. All authors agree that to be effectual in restraining hemorrhage it must be well applied. Various materials, such as a sponge, a handkerchief, tow, cotton, wool, or a roller bandage have been recommended. Pledgets of the material selected may be introduced along two fingers as guide, or through a Ferguson's, a bi-valve or a Sims' speculum. The Sims' position and speculum unquestionably offer superior advantages, and should be selected, except under extreme emergency, when time may be all important. Cotton-wool pledgets should each have a string attached, or be made after the kite-tail principle, to facilitate removal. They should be squeezed out of carbolized glycerine and water (1–40). The antiseptic gauze roller-bandage can be substituted for the muslin "roller" recommended by Taylor. It has the advantage of being already prepared, and it is easy of introduction and removal. After irrigation of the vagina with an antiseptic solution, the patient should be put in Sims' position, the perineum retracted, and the tampon applied by packing first the posterior fornix, then the anterior, and last the vagina down to the outlet (the Sims' method.) This may be reinforced by a pad over the perineum and vulva, and a T bandage. After twelve hours the tampon should be removed, although Charpentier advises that it remain twenty-four or even thirty-six hours. Irrigation should always be practiced before touch, as the tampon, in spite of antiseptics, is apt to cause a foul smelling discharge. The fœtus (if not previously passed) and the fœtal envelopes are frequently removed with the tampon, or are found free in the vagina or cervix. Should retention still exist and the os be closed, the tampon should be reapplied. Should this be removed at the end of twelve hours and retention still exist, we are met with the problem as to whether we shall continue the ergot and tampon treatment, or clear out the uterus at once. According to Lusk, Mundé and Playfair, experience fully proves that where the neck is dilated or dilatable the uterine contents can be removed without danger; and the woman is forthwith protected against hemorrhage, and the dangers of sepsis are reduced to a minimum. The French, almost as a unit, and various other authorities, oppose active interference unless symptoms of sepsis or putrefaction occur. Then they interfere in the usual way.

We believe the best rule to be: if, after twenty-four or thirty-six hours' use of ergot and the tampon, the uterus is not empty: empty it. And with each additional experience the temptation grows stronger to follow the more extreme plan advocated by Lusk and others in these cases—to empty the uterus as soon as you can get a finger into it. If the cervix is not dilated, it may be dilated with hard rubber dilators or tents. Engelmann advises the use of slippery-elm tents. The finger is often the best dilator.

The method of emptying the uterus is not indifferent. The finger is necessarily the safest instrument of removal, as it alone is sensitive. Dull curettes of different sizes are safe and efficient in good hands. But a certain amount of experience is necessary to tell when the cavity is clear of the secundines. Lusk truly says that deliberation and perseverance are the main elements of success. Ether is always an assis-

tance, and is often necessary in nervous and primiparous cases. The patient should be placed across the bed, the hips well drawn to the edge; then the index finger is inserted, and made to pass up one side, across the fundus, and down the other side (the nail in contact with the uterine wall), separating the secundines in its progress. The other hand is made to assist by depressing the uterus from above. The *débris* should be removed as far as possible with the finger, and the remainder washed away with the irrigator. After this a fifty-grain iodoform pencil may be placed in the cavity.

From the fourth to the seventh months the fœtus is usually discharged after rupture of the membranes, the placenta and membranes following or being retained. After this time the process of delivery is similar to that at term. Rarely, the ovum is expelled entire. In such cases the treatment does not differ from that of similar cases in the third month. Interference is not usually demanded until rupture of the membranes. Expectancy should be practiced. After the discharge of the fœtus, which at this time necessitates a considerable amount of cervical dilatation, the way is open for the immediate removal of the placenta and membranes. Ergot and the tampon may be used in the fourth month, but after this the danger of concealed hemorrhage overbalances their advantages. The method of removal does not differ from that for the third month, except that we have more room as the pregnancy advances. During the fifth, sixth and seventh months, a modification of Crède's method at term will often succeed, not only in controlling hemorrhage temporarily, but in expelling the uterine contents.

In certain cases, in which the contents of the womb may or may not be considered to have been discharged, we are called upon to treat the consequences of retention. These are the "incomplete" and "neglected" cases. The patient complains of pains, hemorrhage or septic symptoms subsequent to a miscarriage. Where portions of placenta are retained, with sufficient vascular connection to maintain vitality, a polypoid mass results, with metrorrhagia. Where the vascular connections are less, more or less rapid decomposition ensues. The indication to clear out the uterus is the same in both. In the hæmorrhagic cases, ergot will often expel the mass, but the most certain, most surgical way is to dilate the cervix, and remove the mass with the finger, curette, or polypus forceps. The cervix in these cases is often closed, and for dilatation the Wilson steel dilator is the best. After removal of the polyp it is well to gently curette the cavity, and to apply Churchill's iodine. In the septic cases, with foul putrescent discharge, the os is generally open and dilatable. Here, also, the finger is the best implement, but in cases of difficulty there is danger of self-infection. This is an argument in favor of the curette, in these cases. After removal of the retained mass the uterus should be irrigated with hot bichloride solution (1–2000), and an iodoform pencil, of fifty or one hundred grains, introduced. There is commonly a chill, with a sharp rise of temperature, even to 105° F., shortly after manipulation. This is due to increased absorption of septic matter, caused by the abrasions made during the removal of the uterine contents. Unless systemic infection is marked, rapid improvement follows. If otherwise, the treatment does not differ from that of septic infection from putrescent matter *in utero* at term.

It is scarcely necessary to insist, at this time, when the necessity and value of antiseptic precautions in labor are so fully recognized, that the same rigid exclusion of infectious material from the genitals is of great importance. Personal disinfection of the attendant, especially of the examining or operating finger or hand is the greatest desideratum.

OPERATIONS FOR ABSCESS IN THE BRAIN.

At a meeting of the Medical Society of London, March 5, 1888, Dr. Ferrier and Mr. Victor Horsley read the notes of a case of cerebral abscess associated with a discharge from the ear, in which Dr. Ferrier diagnosticated the presence of an abscess in the brain and Mr. Horsley operated successfully for its

evacuation. As there are but few such cases on record, this one is of peculiar interest. The patient was a man, 47 years old, who had been ill since November 10, 1887, and on the fifteenth had had an offensive discharge from the left ear. On December 8, when Dr. Ferrier first saw him, he was drowsy, and complained of pain on the left side of the head. He had no paralysis. His pulse was 52, weak and intermittent. His respirations were 14 to the minute, labored and sighing. His temperature was normal. After a temporary improvement, he was at the end of six days more drowsy, and in a few days more he developed some delirium and confusion in his speech. There was also some weakness of the right angle of the mouth.

On studying these symptoms Dr. Ferrier came to the conclusion that the man had an abscess of the brain, probably situated in the anterior part of the third left temporo-sphenoidal lobe, and abutting or pressing upon the fissure of Sylvius. Mr. Horsley agreed in this diagnosis, and, on December 9, he operated by trephining the skull, opening the dura mater, and puncturing the brain with a trochar. The result was the evacuation of about five fluid drachms of odorless pus. After this the patient went on uninterruptedly to recovery.

In commenting on this case Dr. Hughlings Jackson described the result as simply magnificent, and other members of the Society joined in his admiration of the acumen and skill displayed by Dr. Ferrier and Mr. Horsley. Similar feelings must be excited in the minds of all who learn its details; and no one can doubt that to these men the patient owes his escape from impending death.

Operations upon the brain are no longer novelties in surgical experience, and they have been brought into prominence especially by the work of certain German and English surgeons. Among the former, Krönlein stands pre-eminent; and among the latter, Horsley. For a correct appreciation of the indications for, and the technique of their performance one must have a knowledge of the anatomy and physiology of the brain, as well as of the phenomena dependent upon the various lesions of it, and some acquaintance with the details which have been better described by Wiesmann, of Zurich, in the *Deutsche Zeitschrift für Chirurgie*, 1885, than by any single writer with whose work we are familiar.

So far very little seems to have been done in this country in the way of operating upon intra-cranial abscesses or morbid growths, or for the relief of intra-cranial hemorrhage; but the time seems to be ripe for some evidence of the same skill in diagnosis and in operative action, which has of late shed so much lustre upon our brothers in Europe. We may be more fortunate than they are, in the apparent lack of opportunity for imitating their boldness; but it is not unlikely that a better knowledge of what may be known of and done for intra-cranial lesions would lead to the detection of opportunities which now go unrecognized.

SCOTCH OATS ESSENCE.

In the number of that outspoken journal, the *Boston Journal of Health*, for March, 1888, there is an article which discusses the character of so-called Scotch Oats Essence, and in which the statement is made that it contains about thirty-five per cent. of alcohol by measure. This statement is placed in contrast to that of the makers and advertisers of this preparation who assert that it is an absolutely harmless vegetable tonic, which will free the victim of the alcohol habit from his terrible bondage.

This interesting contribution to the literature of the Scotch Oats Essence has been followed up by an article in the *Druggists Circular* for April, in which the statement is made that this Oats Essence contains morphine. A careful quantitative analysis disclosed the fact that a bottle contained more than two grains of this alkaloid.

The information secured and published by the two journals mentioned is of great importance to all medical men; for it is not long since this special preparation was advertised in a large number of medical journals, and probably secured some recommendations from members of the medical

profession. At the present time the manufacturers are making continuous and strenuous efforts to secure a large sale for it, and they have not hesitated to proceed by methods which recently resulted in an action being brought against them for the misuse of the name of a well-known physician in New York. It is well, therefore, that medical men should be on their guard against this so-called tonic, and take pains that there shall be no doubt as to their attitude toward a preparation which is claimed to be absolutely harmless, and yet contains such considerable quantities of alcohol and morphine. It is time that physicians took a more active part in suppressing some of the frauds which, in the guise of medical treatment, are practiced on the community; and if the allegations in regard to Scotch Oats Essence are true, it is a first-rate fraud to begin on.

In this connection, we take pleasure in recommending to the appreciation and gratitude of our readers the two journals named above, which are doing such service in investigating and disclosing to the public the ingredients of a number of much-advertised nostrums. Such service is rarely rewarded as it deserves, but it shall not miss whatever recognition the REPORTER can give it.

ANTI-ADULTERATION BILL.

The United States Senate has just passed a bill, introduced by Mr. Edmunds, providing for an inspection of meats for exportation, and prohibiting the importation of adulterated articles of food or drink. It seems that this bill has been introduced and passed in order to give the President power to exercise the pressure of retaliation upon European countries which have excluded certain articles of food—notably pork—sent out from America, on the score of unwholesomeness, but perhaps really because they competed too strongly with products of their own peoples.

But whatever may have been the motive prompting the Senate, it is pleasant to note that a beginning has been made in this important matter. The present bill provides for a government inspector of meats designed for exportation, and forbids the importation into the United States of any adulterated food or liquors. It gives to the President ample power to enforce its provisions against any country from which adulterated articles are imported, and, if carefully carried out, cannot fail to prove of great advantage. It may, and we sincerely hope it will, prove but the beginning of broad and wise measures for the protection of the public health. If the Constitution of the United States does not justify the exercise of such a paternal authority in matters of health as is in force in less democratic countries, we trust that Congress may at least exercise the prerogative of initiating some general movement among the States, so that all over the country there shall be uniform laws protecting the public health.

PENNSYLVANIA STATE MEDICAL SOCIETY.

The time for the next meeting of the Medical Society of the State of Pennsylvania (June 5) is approaching, and it is desired that the programme shall be completed as soon as possible. For this reason, gentlemen who intend to read papers are urged to send their names and the titles of their papers at once to Dr. John H. Packard, of the Committee of Arrangements, 1924 Spruce street, Philadelphia. The time to which applications for a position on the programme is limited, is April 15.

BOOK REVIEWS.

[Any book reviewed in these columns may be obtained, upon receipt of price, from the office of the REPORTER.]

DISEASES OF THE SKIN. By JOHN V. SHOEMAKER, M.D., Professor of Skin and Venereal Diseases in the Medico-Chirurgical College of Philadelphia. New York: D. Appleton & Co.

Considering how little we have advanced in our knowledge of the etiology and pathology of the different skin diseases since the time of Hebra, it is somewhat astonishing to how many exponents in the form of manuals and text-books the intervening years have given birth. For so young a specialty its workers are apparently both numerous and zealous, although of late the most energy has been directed in therapeutic channels. The book before us is the third large octavo volume in this branch which has appeared in the past several months.

This treatise in its general arrangement and descriptions resembles closely those which have preceded it; in fact, its arrangement is almost identical

with that adopted by Duhring. In a few respects, the author swerves from the usual classification, evidently following in this respect "Robinson's Manual." Lichen planus and lichen ruber are considered, for alleged pathological reasons, as distinct diseases, and not as different phases of the same process as generally accepted. The first is placed under the inflammations, and the latter under hypertrophies. The correctness of this view, however, has been denied by other investigators. Psoriasis has been transferred from the inflammations to the hypertrophies. This tendency to reclassify, upon individual investigations alone, does more to mystify than to aid in the advancement of our knowledge. Classification depends upon the sum of our information, and although all data are valuable as tending toward a clear understanding, until more or less unanimity obtains a new departure is scarcely justifiable. In the present instance, therefore, the author does not carry out his intention as expressed in the preface "that the whole work has been written from the standpoint of an active general practitioner, and can hardly fail to bear that impress." The chief complaint of the general practitioners against dermatologists has been the incessant and confusing changes in the names and classification. It will be difficult to explain intelligibly to the general practitioner, with the inflammatory signs of psoriasis before him, that the disease is a hypertrophy, and it is only just to the general medical public to add that as yet such a view of the disease is far from accepted by the dermatological world. The author offsets this slip, however, in incorporating in the work a consideration of the cutaneous symptoms of the exanthemata. We believe that such should find a place in every text-book on diseases of the skin. No mention is made of the disease, or group of symptoms, known as dermatitis herpetiformis. Under this or another name these cases demand recognition.

So much has been written by Dr. Shoemaker in regard to the therapeutics of skin diseases, that naturally this part of the work was expected to be the strongest, but on the contrary it is disappointing, although in many respects original. The oleates are still in favor with him, although, with few exceptions, they have after trial failed to find a permanent place in the therapeutic resources of those specially engaged in dermatological practice. The author states his confidence in sulphur as one of the most valuable remedies in the external treatment of chronic eczema. This is contrary to general experience. It is true, it is useful in certain cases, but the number is extremely limited; in most instances it will be found to aggravate, and under all circumstances should be employed cautiously. On the other hand, the author refers but briefly and subordinately to the usefulness of sulphur and its preparations in acne and rosacea. In sycosis, also, the same remedy is scarcely mentioned, although beyond doubt, when judiciously prescribed, it is the most valuable in the whole list. In short, if we take him at his word, the author is able to cure his cases on lines of treatment quite different from those usually adopted by dermatologists.

The micro-photographs which accompany the text are excellent; the colored plates, with one or two exceptions, are simply atrocious. With this exception, the publishers' part of this book is well done.

—Numerous foot-ball accidents in the way of broken limbs are being reported by the English journals.

MODERN TREATMENT OF HEADACHES. By Allan McLane Hamilton, M.D. 5½ x 7 inches, pp. 124. Detroit: Geo. S. Davis, 1887. Price, 25 cents.

This book is the November number of the "Physicians' Leisure Library." It contains an excellent account of the different varieties of headaches and very valuable suggestions in regard to their treatment. The author sends it out with a modest preface; but we believe it is a book calculated to be of great service to every physician. We are glad to be able to speak more favorably of it than we have done of some of the numbers of this series, the design of which is good, whilst its execution has thus far been very unequal. We must, however, call attention to some defects which we presume are chargeable to the proof-reader; for we cannot believe, for example, that Dr. Hamilton would be guilty of the errors which are to be found in his prescriptions as printed in this book. These errors, it must be stated, do not affect the value of the formulæ, although they will offend those who respect accuracy of statement and correct spelling. The book is a good book, and may be safely recommended to our readers; but before it goes to a second edition the errors we refer to ought to be eliminated from it.

Pamphlet Notices.

Medical Organization. By A. N. Carrigan, M.D. From Transactions of the State Medical Society of Arkansas. 4 pp.

—Dr. Carrigan, who has died since he read this paper at the twelfth annual session of the Arkansas Medical Society, makes in it, an earnest plea for the formation and hearty support of county medical societies. These he regards as the starting-point for advancement in the republic of medicine, and as a great means of education and cultivation in the art of medicine.

Literary Notes and Queries.

[In this column the Reporter will publish short items of literary interest and questions addressed to this Journal or its readers, and answers to them, in regard to any literary matters: books, authors, places and prices of publications, etc.]

—*Babyhood* for March continues the useful work which this magazine began about three years ago. It contains much valuable information for parents, especially mothers, and for intelligent nurses. By far the best part of this is that contained in the editorial departments, while the original articles are very good, even if some are a little too technical for the nursery.

—The *Boston Journal of Health* is a wide-awake, interesting and useful monthly, each number containing about sixteen large quarto pages. Subscription price, $1.00 a year. Just now it is exposing with great vigor the claims of a number of quack remedies. The number for February devoted considerable space to an analysis of what is known as "Murdock's Liquid Food," and the number for March follows this up with a refutation of what appears to be a rejoinder. This sort of thing makes interesting reading, and, we believe, is calculated to do much good.

Correspondence.

Prescribing Druggists.

Editor Med. and Surg. Reporter:

Sir:—Although not a doctor, nor even a "prescribing" druggist, I am a constant reader of the Reporter, and have been for a number of years. I have just read the tirade of B. P. Reese in the last issue, and wish to protest against his wholesale denunciation of druggists, because he has cause of complaint against a few black-sheep in the fold of pharmacy; I do not offer any excuses for, nor uphold "prescribing druggists." Like "rum" drug-stores, there is no excuse for them.

But who are the prescribing druggists? Nine out of every ten are like the particular one referred to by Dr. Reese, *i.e.*, M.D's. engaged in the drug business; not pharmacists, nor chemists, but simply doctors assuming a profession that they are not as capable of filling as the average pharmacist is of prescribing for a cough, cramp in the stomach, or other minor complaint. We would like the doctor to suggest some way to teach physicians "to confine *themselves* to their legitimate business," and stop the growing evil of overcrowding our business, or we will be compelled to get an M.D. diploma and practice medicine ourselves.

It is not a fact that "druggists do all in their power to deprive the physician of his fee." On the contrary, as a class, we are always willing and glad to extend to the physician such help and professional courtesy as we can. The M.D. druggists may, and do, absorb the total fees; but there is no way nor use of retaliating, as not many of them have much prescription business outside of their own practice, so that a "boycott" will not remedy the trouble.

Has a doctor, or anyone, a right to prescribe for a patient he has not seen or examined? Preferably not; yet observation shows that not less than half of the prescriptions for coughs and the minor ailments are written by physicians in good standing, on the word of another without seeing or examining the patient. Would you deprive your brother in the profession of the same privilege because he is engaged in the drug business?

Aside from ethics, there is a legitimate demand among the poor and those of limited means, who are not able to fee a doctor for every "grunt," for cheap remedies for those ailments, as evinced by the frequent calls for "a nickel's worth of hive-syrup, paregoric, Brown's mixture, etc.," and the number of "receipts for cough syrup" of domestic origin, as well as the demand for "patent medicines." Should not a pharmacist be as competent to prescribe a good cough syrup, or worm powder as a doctor who has not seen his patient, or the patent nostrum maker? This demand will always exist, and if not supplied by the druggist, it will be by the grocer or dry-goods man. You may legislate at it, and control it by inspection, as should be done with proprietary articles; but you can't stop it any more than you can prevent a mother from giving catnip tea or paregoric to a sick baby, or the mechanic from filling a fresh wound with tobacco juice.

There are just causes of complaint on both sides, and there is no use in denouncing your co-workers as a class because a few offend. "Let us have peace."

Yours truly,

Sharon, Pa., A. L. Beck, Ph. G.
March 17, 1888.

A Physician's View.

Editor Med. and Surg. Reporter:

Sir:—I notice in the Reporter of March 10, an article from B. P. Reese, of Virginia, on the "Prescribing Druggist." This subject is one, owing to the crowded condition of the ranks, that should elicit the attention of the medical profession. It is very obvious that the druggists are, through this medium, annually taking many thousands of dollars that belong to the physicians. The notion of the people in going direct to the druggist to prescribe for their chronic aches and pains is truly an unnatural state of affairs. Nevertheless, custom has established this notion in the minds of one-half, if not more, of the people, and they do it, and will continue so to do, irregardless of all the laws the Legislature can pass. One-half, at least, of the people do not comprehend the value of a correct diagnosis, and they absolutely realize the fact that the physicians, as a rule, don't handle medicines, but only give prescriptions; consequently, as they don't place the proper value on advice and prescriptions, it is a minor matter with them; and with the view of saving the charges for such they go direct to the druggist, and leave the physician out of the deal, and it is not very often that the druggist sends them back to the physician; but he caters to please them, and that in his own interest, amply supplied with the remedies suited exactly to his own peculiar business, such as syr. hypophosphites, liquid lactopeptine, bromo-caffeine, and many others that could be mentioned,

and so moves the business. Now, the law to stop this resides within the medical profession, proper. Let each physician keep and compound his own remedies for his patrons, and the result will be: in place of the people going to the druggists, they will go to the physician; his office practice will be increased; it won't take the number of patrons that it does at present to support each physician; the people will be better satisfied; the dignity of the profession not a bit lowered, and its power to protect its own interest greatly increased.

Yours truly,

CHARLES W. MUSGROVE.

Austinville, Pa.
March 20, 1888.

Statistics of Consumption.

EDITOR MED. AND SURG. REPORTER:

Sir:—In the MEDICAL AND SURGICAL REPORTER for March 24, 1888, there appears an interesting though deceptive article from the pen of Dr. Sozinskey, entitled *Sex in Consumption*, which is tacitly intended as a refutation of the deductions in my paper on *Female Dress as a Determining Factor in Pulmonary Consumption*, and published in the *Medical News*, January 7, of this year. In this paper I maintain that the female is less liable to pulmonary consumption than the male, because she possesses a greater apical expansion; and had I not taken for granted in its preparation—though it appears without sufficient justification—that the absolute worthlessness of the United States census reports for securing reliable mortality statistics is universally known and admitted, this brief reply would indeed be entirely unnecessary. Any one who has had the least intelligent experience in gathering vital statistics knows full well that no data exist in this country which are worth computing except those coming from the larger cities, and perhaps from one or two of the smaller States. Outside of these sources no pretensions are even made to collect reliable mortality statistics save by the census-taker, who comes around and guesses at them every decennium. In proof of this assertion, and for the benefit of the few who still persist in hugging the delusive phantom that the census statistics are immaculate, I beg to quote the language of Prof. Francis A. Walker, Superintendent of the Ninth Census, and whose authority on this point is unquestionable. He says: "The failure of the census to reach the object proposed is perhaps nowhere so conspicuous as in the returns of the deaths occurring during the census year. The reasons for this comparative failure are not obscure or remote. Statistics of mortality can only be satisfactorily obtained as the result of a system of registration maintained without interruption and rigidly enforced by penalties. In the census of the United States, on the contrary, it is sought by an occasional enumeration to recover information of all the deaths which have occurred during the twelve months preceding. It is not wholly a matter of blame to the agents of the census that such an effort results in the return of but 60, 65 or 70 per cent. of the deaths which we know must have occurred during the period covered by the inquiry.—(The Relations of Race and Nationality to Mortality in the United States. Reports of the American Public Health Association, volume I., page 18).

It would be simple madness to anticipate anything satisfactory from such sources, and therefore I addressed myself to an examination of the health reports of all the American and foreign cities to which I could gain access, knowing that they have *a system of registration maintained by rigidly enforced penalties*, such as is described by Professor Walker, and under these circumstances I I think it requires but little "acuteness and strength of wit" to decide whether Dr. Sozinskey's figures or my own are spurious or real.

The conclusions presented in my paper I consider irrefutable so far as I know at present, and I furthermore feel quite certain that, in order to assail them successfully, a stronger armament is needed than a few quotations from the United States census report.

Yours truly,

THOMAS J. MAYS, M. D.

Philadelphia, March 26, 1888.

—Dr. O. Barbacci reports to the *Centralblatt f. d. med. Wissensch.*, the result of his estimation of the hæmoglobin with Fleischl's hæmometer in twenty-eight cases of decided chlorosis. He finds the average percentage of hæmoglobin about 44 per cent. of the normal, varying between 39 and 50 per cent. After the employment of iron for from two to four weeks an increase of the quantity of hæmoglobin to the extent of 10 to 30 per cent. occurred regularly, along with the improvement in the general health. This condition then usually continues stationary for a long time, but even in slowly progressing improvement the normal quantity of hæmoglobin is never attained.

Notes and Comments.

Malarial Congestion.

In a paper read before the Tri-State Medical Association of Mississippi, Arkansas and Tennessee, Dr. J. A. Lipscomb, of Memphis, stated that 10 per cent. of the deaths in Memphis during the months of July, August and September were caused by malarial congestion. He believes that the difference between the ordinary and the congestive, or pernicious paroxysm, is only one of degree. Cases classed as congestive may be arranged, for practical purposes, under one of the five following groups: the comatose, the spasmodic, the pulmonary, the choleraic and the algid. In the first group the poison seizes upon the brain; in the second upon the cord and medulla; in the third upon the respiratory organs; in the fourth upon the digestive organs, and in the fifth upon no special more than another, unless it be the skin. The leading indications are to bring about reaction, and then to bring the system as speedily as possible under the influence of an antiperiodic. He freely concurs in the following opinion expressed by Dr. Davidson:

"No time is to be lost in relieving the patient from the lesion of innervation and bringing about reaction. Delay in experimenting with sinapisms, plasters and stimulants is time thrown away, and will disappoint the expectations of the physician."

Dr. Lipscomb then declares: "While the depressed condition of the heart's action continues, with the serum of the blood exuding through the paralyzed capillaries of the whole mucous surface of the bowels, and the copious transudation through the skin exhausting the patient and deepening the collapse, calorification is difficult to restore. All means therefore for arousing the energy of the nervous system, and thus restoring the lost tone to the tissues, must be resorted to. What then are the means best adapted to these ends? In my humble opinion, the shock produced by the cold douche, conjoined with the hypodermic injection of morphia and atropia, or of strychnia, or of atropia and digitaline, as the indications may require."

As to the best way of applying the cold water, he has adopted the plan of pouring it from the pitcher, held as high above the patient as is convenient and allowing it to fall directly upon the back of the head and neck and down the spine. After having used several gallons of water in this way, he has the patient wiped dry with towels and wrapped in dry blankets, and given a hypodermic injection of atropia, or of atropia and morphia, or of strychnia, as may seem to be indicated. If reaction does not take place in half an hour, he repeats the douche, and wraps the patient in the blankets as before. If there is great restlessness with vomiting, morphia and atropia subserve the best purpose; if great nervous depression with sighing respiration, strychnia increases the muscular tonicity and stengthens the action of the heart, as does also digitaline.

If by these means, he says, you have succeeded in establishing reaction, lose no time in meeting the second indication, namely, that of bringing the system under the influence of quinine. He cautions the physician, however, against letting anxiety to meet the second indication get the better of his judgment, and so commence the quinine too soon. Before reaction is established and the nervous centers liberated from the depressing effect of the poison, quinine will add to the depression and sink the patient into a condition of collapse from which it will be difficult to relieve him, even if it can be done at all. He is satisfied that he has seen this happen more than once in his own practice, as well as in that of others. Having thus succeeded in establishing reaction, he advises to proceed at once to meet the second indication by the administration of quinine. The preparation of the remedy and the avenue by which it is to be administered, so as to most speedily bring the system under its antiperiodic effect, he regards as matters of grave importance. It does no good to give it by the mouth—for if it is not rejected it will not be absorbed; and the same objection may be urged to giving it by the rectum. The hypodermic method he regards as the only one to be thought of, and the bisulphate, being the most soluble, as the best preparation. One drachm of of this salt dissolved in an ounce of hot water and filtered makes a very nice solution and is less often followed by abscesses than a solution of the sulphate. One drachm of this solution representing seven and one-half grains may be injected under the skin every hour or two as the exigencies of the case may require. Since adopting this plan of treatment he has had better success than with the old one, and thinks he has saved some valuable lives.—*Memphis Med. Monthly*, March, 1888.

Salts of Nickel.

The use of nickel and nickelled utensils tends to spread more and more. M. Van Homel Ross, having recognized by various

physiological experiments, the innocuity of this metal protests against a decision of the Superior Council of Hygiene in Austria, tending to prohibit the sale of nickel cooking utensils. Dr. Blayae read the work of this learned chemist at a recent meeting of the Academy of Medicine of Paris. The opinions of chemists differ. Orfila decides neither one way nor the other; Hussel, declares that nickel is more dangerous than iron; Simpson, compares it to zinc or tin, with regard to its poisonous properties; Anderson considers it as dangerous as and similar to picrotoxine; Dragendorf declares that it is a very dangerous substance, and says that a dose of a single milligramme of acetate liquifies the globules of the blood, and destroys them. Professor Riche has made several experiments on guinea-pigs administering acetate in large doses. One died immediately of pneumonia as confirmed at the autopsy by Dr. Laborde, the other is quite well. A dog felt no ill effects after having received 25 grammes of the same salt at the rate of 50 centigrammes per day; on another dog, the dose of 50 centigrammes had no effect; it was then increased to 75, to a gramme and 2 grammes. At this last dose the animal did not die but was taken with vomiting, a chronic diarrhœa, and a sort of ataxy of the hind quarters. The symptoms disappeared rapidly when the dose of the salt was decreased to ½ gramme and the animal, which had become thin, soon fattened up again. The animal was killed and the autopsy proved there was no trace of injury. It is impossible to decide from the dog to man, but what has been shown in the course of this last experiment goes to prove that the extremely small quantity of nickel salts entering into substances cooked in vessels of this material has no hurtful effect. Nickel employed in cooking is not more dangerous than iron, which it approaches in its chemical composition.

Art in the Home from a Medical Standpoint.

Dr. I. N. Love says: "I would sooner hang in my home a ten cent chromo of a cheerful and pleasant subject, than the grandest creation of a Gabriel Max, if it present the horrible side of life as does his "Infanticide." Hanging scenes and revolting representations of morgues, may be very artistic in that they are true to nature; and even though it may be true, as has been stated (though I doubt it), that art has nothing to do with morality or immorality, I believe their proper place along with the nude in art to be art galleries and museums. And I consider anatomical and pathological pictures with skulls and skeletons as part of the belongings of a medical college, or of the inner hidden closets of the doctor's office. They are of the shop, shoppy, and in exceeding bad taste when exposed to the view of patients.

It may be true that the nude in art has rendered holy the beauty of woman and the strength of man; but I question the propriety of placing before the eyes of the undeveloped, uncultivated, or non-professional, much in the way of nude in art, just as I would hesitate to open a male and female surgical clinic to the gaze of children or a lay public."—*Weekly Med. Review*, March 17, 1888.

Influence of Obesity in Young Women upon the Menstrual and Reproductive Function.

In a paper read before the Medical Society of the State of New York, February 7, 1888, Dr. Andrew F. Currier, concluded from the testimony presented, that obesity occurring in young women caused disordered menstruation, and usually sterility, whether the patient had previously borne children or not. If utero-gestation were completed in such patients the child was likely to manifest deficient vitality. The quantity of the flow was almost always less than normal, of abnormal quality, the duration a few hours or a day. Pain was an almost constant symptom. It was in the sacral region in nearly all cases. Vicarious menstruation was common. Constipation was usually present. There was often an hereditary predisposition to early obesity. It might be brought on by luxurious habits, sluggish disposition, passive sexual indulgence, free use of starchy and saccharine foods. Suggestions as to treatment were based on the etiology.—*N. Y. Med. Journal*, Feb. 11, 1888.

Mouth-wash.

The *Chemist and Druggist*, March 17, 1888, says a teaspoonful of a lotion prepared according to the following formula, in a wineglassful of warm water, used every morning as a mouth-wash, is good for restoring firmness to the gums when the teeth are loose:

Tannin	1½ drachms
Iodide of potassium	12 grains
Tincture of iodine	1 drachm
Tincture of myrrh	1 drachm
Rose-water, to	6 oz.

Dissolve the tannin and potassium iodide in the rose-water. To this add the tinctures, and strain.

Compulsory Vaccination.

The following quotation from *The Sanitarian* would seem to indicate that a compulsory vaccination law has its advantages: "The success of the anti-vaccinationists is aptly shown by the results in Zurich, Switzerland, where for a number of years, until 1883, a compulsory vaccination law obtained, and small-pox was wholly prevented (not a single case occurred in 1882). This result was seized upon in the following year by the anti-vaccinationists, and used against the necessity for any such law, and it seems they had sufficient influence to cause its repeal. The death returns for that year (1883) showed that for every thousand deaths two were caused by small-pox; in 1884, there were three; in 1885, seventeen; and in the first quarter of 1886, eighty-five."

Wart-Charming Extraordinary.

A well-known and old-established firm of chemists in Birmingham, England, is doing a lucrative trade in charming away warts. The *modus operandi* is somewhat novel. The principal partner in the business gravely examines the warts, counts them, and instructs the patient to depart and return in a week's time. The order is obeyed, and when the individual makes his appearance on the second occasion, the chemist places on each wart a piece of bacon which he has prepared in the interim, indulges in a solemn incantation, tells the patient he must not thank him, and quickly walks away. The warts are said to wither away in the course of a few days afterwards. —*Chemist and Druggist*, Feb. 4, 1888.

The Philadelphia Polyclinic.

The remaining evening lectures in the Polyclinic course will be given on the following dates at the Polyclinic building, Broad and Lombard streets.

April 10.—Prof. Arthur Van Harlingen: The Management of Eczema in Old People.

April 20.—Prof. J. Henry C. Simes: The Treatment of the Primary Lesions in Syphilis.

April 24.—Prof. Edward Jackson: The Character and Significance of the Retinal Lesions Associated with Bright's Disease.

May 1.—Prof. Alexander W. MacCoy: Observations on the Pharyngeal Tonsil.

May 11.—Prof. H. Augustus Wilson: Treatment of lateral Spinal Curvature.

May 22.—Prof. Solomon S. Cohen: Respiratory Therapeutics.

Medical Association of the State of Alabama.

The Medical Association of the State of Alabama will hold its annual session at Montgomery, Alabama, beginning *Tuesday, April 10*, in the U. S. Court Room (P. O. Building), where the secretary and treasurer will be in attendance every morning. The first day's meeting will be largely taken up with business matters, but will include an Address of Welcome by Dr. W. G. Gibb; the Annual Message by Dr. E. H. Sholl; and the Annual Oration at 8 P.M., by Dr. B. J. Bodwin.

Wednesday, April 11.—Morning Session.—The following papers will be read:

The Value of Exploratory Incisions—William Locke Chew, M. D., Birmingham; The Radical Cure of Hernia—Luther Leonidas Hill, M. D., Montgomery; The Practical Investigation as to the Therapeutic Value of Salicylate of Hydrargyrum—Henry Tutwiler Inge, M. D., Mobile; Studies in Eczema—Arnold Jolly, M. D., Linden; Electricity in Uterine Diseases—Mortimer Harvey Jordan, M. D., Birmingham; Physiological and Pathological Heredity—James Thos. Searcy, M. D., Tuscaloosa; Diarrhœal Diseases of Children in Western and Middle Alabama—William Henry Sledge, M. D., Livingston; The Medical Topography of Walker County and its Prevailing Diseases—Alexander McAdams Stovall, M. D., Jasper; Color Blindness and Defective Vision in Relation to the Traveling Public and the Railroads—Robert Dickens Webb, M. D., Birmingham; Studies in Rectal Surgery—Benjamin Leon Wyman, M. D., Birmingham.

Evening Session.—Discussion of the best methods of administering the health laws, and the law to regulate the practice of medicine.

Thursday, April 12.—The Omnibus Discussion—Milton Columbus Baldridge, M.D., of Huntsville, leader. Topics: 1st. Typho-Malarial Fever. 2d. Hereditary Diseases. 3d. Influenza. 4th. Pain as a Symptom of Disease. 5th. The Knife in Uterine Surgery; its uses and abuses. 6th. The Medical Treatment of Old Age. 7th. Rheumatism and Gout.

Certificates are placed in the hands of ticket agents, who will furnish them to delegates and others upon application at the time tickets for the going journey are purchased, but *no refund of fare will be made on any account whatever because of failure of the parties to obtain certificates.*

NEWS.

—Cholera is still prevalent in Chili, and fears are entertained lest it may also pass the boundary into Peru.

—It is reported that Professor Fritsch, of Breslau, is to be offered the chair of midwifery at Würzburg, made vacant by the death of Scanzoni.

—The St. Louis Medical College held its annual commencement, March 8, and graduated sixteen men as physicians, and one hundred and thirteen as dentists.

—The Twentieth Annual Session of the Texas State Medical Association will be held in the city of Galveston, beginning Tuesday, April 24.

—The oldest man in Germany is called Wapniarek, and lives at Hutta, near Gresen, in the province of Posen. He was born in 1764, and is consequently now in his 124th year.

—Deaths from small-pox and yellow-fever still continue to occur at Havana, Cuba. For the week ending March 17, there were twenty-one deaths from the former disease, and three from the latter.

—An Act has passed the Iowa Assembly which requires druggists to label every package of poison they sell with two antidotes to the drug, as well as the word "poison," which is now placed on every such package.

—Dr. D. W. Cullimore states in a letter to the *Medical Press and Circular*, March 14, 1888, that he has obtained very good results in the diarrhœa of locomotor ataxia from the use of cocaine by suppository.

—French pharmacists are anxious to make and dispense antipyrine without bringing themselves into conflict with the German patents, which control its manufacture under that name. It has been suggested to make and dispense it under its proper chemical name (*dimethyloxyquinizine*), which would be awkward, or as *analgesine*.

—The *Popular Science Monthly*, April, 1888, says that Mendeljeff has, by a study of specific gravities of mixtures of alcohol and water, arrived at the conclusion that there are three definite hydrates, containing respectively three and twelve molecules of water to one molecule of alcohol, and three of alcohol to one of water. The first of these has been obtained in the crystalline form at the temperature attained by a mixture of solid carbon dioxide and ether; the second solidifies at—17°.

HUMOR.

A MAN IN A PRAYER-MEETING once prayed for the absent who were "prostrated on beds of sickness and sofas of wellness."

"THE DOCTOR SAID he'd put me on my feet again in two weeks." "Well, didn't he do it?" "He did, indeed; I had to sell my horse and buggy to foot the bill."

DOCTOR—WELL MY DEAR SIR, what seems to be the seat of your disease? Patient—It doesn't seem to have any seat, doctor. It's just jumping up and down all the while.

YOUNG MAN (AIRILY)—Excuse me, but haven't I seen you face before? Colonel Scrap (who suffers from dyspepsia)—Quite likely; I've never worn it behind.—*Life*.

OBITUARY.

THOMAS B. CURLING, F.R.C.S.

Mr. T. B. Curling, who was for many years surgeon to the London Hospital, died at Cannes, March 4. In a paper presented at his instance to the Royal Medical and Chirurgical Society, in 1846, Mr. Curling spoke of the possibility of seeing the fundus of the eye, and of the usefulness of such investigation as an aid to diagnosis. The paper thus anticipated the ophthalmoscope.

WILLIAM B. GOLDSMITH, M.D.

Dr. William B. Goldsmith, Superintendent of the Rhode Island Butler Asylum for the Insane, died at Providence, March 21, in the thirty-fourth year of his age. He succeeded the late Dr. Sawyer as Superintendent of Butler Asylum two years ago. He was graduated at Amherst College, and was educated for special practice in insanity. He passed two years in hospitals in London, Edinburgh, and Germany, and began professional practice at the Bloomingdale Asylum, New York, under Dr. Nichols. When twenty-eight years old he was called to the Superintendency of the hospital in Danvers, Mass., and stayed there until invited to go to Providence.

Official list of changes in the Stations and Duties of Officers serving in the Medical Department, U. S. Army, from March 25, 1888, to March 31, 1888:

Major J. P. Kimball, Surgeon, granted leave of absence for two months, to take effect about April 10, 1888. S. O. 68, A. G. O., March 23, 1888.

First Lieutenant W. D. Crosby, Assistant Surgeon, granted leave of absence for two weeks. S. O. 29, Dept. Ariz., March 16, 1888.

Captain Thomas F. Azpell, Assistant Surgeon (retired). Died March 12, 1888, at Fort Lee, N. J.

There have been no changes in the Medical Corps of the Navy, for the week ending March 31, 1888.

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Clinical Lecture.

LYMPHADENOMA OF THE NECK.[1]

BY PROFESSOR TERRILLON,

SURGEON TO THE SALPÊTRIÈRE, PARIS, FRANCE.

Gentlemen:—I am going to speak to you to-day of a relatively infrequent affection, of which we have a typical case in a patient 25 years of age, lying in No. 21, Ward Sainte Vierge. Last May, about six months ago, this young man first noticed a little lump under the left sterno-mastoid muscle. This swelling at first increased very slowly, but in July it became the seat, at two separate intervals, of a rapid growth, which has resulted in the voluminous mass which you see to-day.

The tumefaction which now presents itself on the left side of the neck is at least as large as the two fists, and extends from the lobule of the ear to the clavicle, and from the median line in front to two fingers' breadths behind the sterno-mastoid. The skin, which is a little red, does not take part in the swelling; the derm is free, but the subcutaneous tissue has lost its natural suppleness, and does not slide easily over the deep parts. On palpation, you find that the tumor has a lumpy feel, that there are irregular fissures, and that the whole mass is hard. If you endeavor to move the tumor, you experience a certain difficulty; it does not appear to be adherent to the subjacent bony parts, but there is a partial attachment; it extends quite deeply, and displaces the larynx, by at least two fingers' breadth, to the right of the median line. Despite all this, during the movements of deglutition the larynx and trachea rise and fall without stirring the tumor, which proves that the basis of the latter is not the thyroid body. The vessels of the region and the œsophagus seem to escape compression; there is neither œdema nor dysphagia.

In short, the tumor inconveniences the patient, but does not cause him to suffer; he feels no pain either in the shoulder, the ear, or the back of the neck. From all this we conclude that the nerves are pressed backward, but not incorporated in the morbid growth.

What has become of the sterno-mastoid? You see it distinctly only in its inferior position; you have reason to suspect that it is to be found in front of and outside of the tumor over which it is stretched; the latter extends beyond its anterior and posterior border. In the supra-clavicular hollow on both sides, and in the axillæ, you find a few glands as large as hazel-nuts. The patient has not perceptibly lost flesh or strength, and the blood when examined under the microscope does not present an excess of white globules.

After what we have just seen, the diagnosis would not seem to be a matter of great difficulty; it is a glandular affection. But what is its nature? This is the main question. You know that in the neck we may observe three sorts of swellings of the glands: 1. Acute or chronic inflammatory swelling; 2. Secondary adenopathies, consecutive to lesions more or less distant; 3. Non-inflammatory, spontaneous adenopathies.

We may at once eliminate the first variety; our patient has no trace of inflammatory affection. We can also rule out the second group; there is no lesion in the vicinity which can explain this glandular intumescence. We have inspected with care the interior of the mouth, the tonsils, the phar-

[1] Translated, with the author's permission, by E. P. Hurd, M.D.

ynx, and our examination has been negative. Moreover, you have under observation in our wards three patients who present typical cases of secondary degeneration of the glands of the neck, and you see at once that the aspect is very different from that of the patient under consideration. There remains, then, the third variety, spontaneous adenopathy. Here, if you will recall to mind what you have been before taught, you will find that this glandular affection may be arranged under four heads: 1. Tuberculous glands. 2. Simple hypertrophy of the glands. 3. Lymphoma, or lymphadenoma. 4. Lympho-sarcoma, or cancer of the glands. Let us pass in review each of these varieties, and see to which one of them the particular case now before us best corresponds.

1. When a gland is invaded by tubercle granules it increases in size, and becomes caseous, softens, inflames and suppurates, and this is what happens especially in young people. Our patient has passed the age at which we ordinarily observe this kind of affection. Moreover, his swelling is voluminous, hard, and there is no point of softening. Lastly, his general condition rules out the idea of tuberculosis, even existing as a local trouble.

2. When a gland undergoes simple hypertrophy, it doubles, triples in volume, but does not change its appearance: the glands remain independent, they do not become agglutinated; between them, in a word, there is no peri-adenitis. Lastly, if this hypertrophy becomes general, we have the *adenia* of Trousseau, with or without leucocythæmia. Now, our patient has a bunch of glands which are soldered together, but there is neither generalization nor is there any numerical alteration in the globules of the blood.

3. It remains now to examine the two last groups of our classification, and you know that it is not a very long time that we have known these lesions. In cases of lymphomata or of lymphadenomata, the glands are augmented in volume, and this hypertrophy is constituted by a modification of their structure, which may take on two forms: (*a*) The soft form, in which the cellular element predominates, and undergoes hyperplasia; the glands are then soft and almost fluctuating; (*b*) the hard form, in which the connective tissue is thickened and undergoes hyperplasia, transforming the glands into firm tumors of fibrous consistency.

Whatever may be the histological modification, it is necessary to bear in mind that this affection which takes on at the onset the characteristics of a benign tumor, may afterwards behave like the most malignant growths. The special clinical character of this kind of tumor is to begin in a single gland, and to grow by the adjunction of neighboring glands, which become agglomerated with the first one, and so on. Thus constituted, this glandular tumefaction ends by acquiring a large volume, but it presents a special characteristic, it presses back the neighboring organs and the skin without invading them, without incorporating them into itself, a property which belongs to malignant tumors. Lymphadenoma possesses already a malignant character when there exist concurrently secondary tumors, which are easy to detect when they are cutaneous (nodules described by Prof. Trélat), difficult or impossible to diagnosticate when they are seated in the liver, the lungs or the viscera. It is probably in cases of this kind that surgeons have witnessed speedy relapses and a rapid spread of the disease after the ablation of the primitive growth. Note in passing, that the cervical region, which is affected in the case of our patient, is a place of election for the localization of these glandular lymphomata.

4. Lastly, we have the lympho-sarcoma, which is only sarcoma or carcinoma of the glands. In these cases the envelope of the gland is quickly invaded and traversed, and the peripheral tissues are incorporated in the morbid mass. Lympho-sarcoma evolves rapidly; the skin is affected and ulcerated in less than ten or twelve months. Its principal character, then, is to be spread rapidly, and as it invades the neighboring tissues, it early provokes pain, which is often very intense and persistent. It will not do, however, for you to deceive yourself by supposing that pathological anatomy knows any absolute difference between lymphadenoma and lympho-sarcoma, for I have many times intimated to you that these two affections may at a given moment of their evolution present a common clinical character, namely, malignity.

After this summary survey of the subject, we may, I think, conclude that our patient is affected with lymphadenoma of the hard variety before mentioned. The progress of the tumor has been relatively slow. The glands are agglomerated, but in the midst of the common mass you detect them here and there by the little lumps which you so plainly feel; those of the neighborhood, still isolated, show us how the affection commenced; the skin is not invaded, nor are the deep organs of the region, which are only

pressed aside. Lastly, the general condition of the patient is good. Have we any means of inferring what will be the course of the disease?

Have we to do with one of those cases which become fatal by extension of the disease, even to the distant parts? Have we, on the other hand, reason to hope that this is one of those curable cases of which instances have been cited? It is unfortunately impossible in the present state of science to give a definite answer to this question; it will be necessary to wait at least until we shall have made trial of the treatment which seems appropriate to the case. It is true that the general health of our young patient is very good; there is nothing like a general extension of the disease; we have found none of those cutaneous nodules just mentioned, nor any indication of a visceral neoplasm; but we have no guaranty that there will not be an outbreak of the malady, similar to that which he suffered in July. Our prognosis must therefore be reserved.

Treatment.—As you may have inferred already, we have to choose between medicine and surgery; either we must be content to give certain internal remedies, or we must endeavor to effect total extirpation of the morbid growth.

The extirpation of diseased glands in the neck, recommended and condemned in turn by authorities, is evidently a difficult operation; it has been regarded as very questionable in cases of lymphadenoma, although, by reason of the fact that the neighboring organs are not adherent to the glands, the latter may be removed in their entirety. I could then, with safety, attempt the ablation of this glandular tumor—and there is nothing about the operation to deter me; in view, however, of the results heretofore obtained from surgical interference in cases of this kind, I think that I had better not interfere. Almost all patients who have been operated upon in like conditions have died in the course of a few weeks from generalization of the disease. I might refer you for your enlightenment to the discussion which took place in reference to this very subject at the Society of Surgery in 1877, when Professor Trélat presented his report. We shall, then, have to fall back upon the medical treatment. I shall not take up your time by enumerating all the remedial means which have been at different times proposed and abandoned, but shall speak of only two medicaments which seem to have given good results. I refer to phosphorus and arsenic. Professor Verneuil recommends the employment of phosphorus under the form of phosphorated oil:

Oil of sweet almonds.....30 parts.
Phosphorus..... 1 part.

M. Dose—Five to ten drops. Good effects are claimed from this preparation. [It has a disagreeable lucifer match taste, which causes patients soon to object to it, in which event the phosphorus can be given in pills.]

Arsensic has seemed to give better results. This medicament has been already given in cancer. Billroth, Winiwarter and Tholer have tried it thoroughly in lymphadenoma, and if it does not always cure, improvement always seems to attend its use.

The arsenic may be administered in two ways. You may either introduce it hypodermically, in which event a few drops of Fowler's solution should be injected deeply into the interstices of the swelling, or the same preparation may be given by the mouth. In the case of our patient, the swelling is too voluminous to warrant us in attempting the hypodermic method; the injections would have to be too often repeated before all the glands would be affected thereby, and besides, the administration by the mouth generally succeeds very well. We shall, then, adopt the internal treatment, which has given marvellous results; in this very hospital our predecessor, Berger, has had what seemed to be several remarkable cases from this method of treatment.

The mode of administration is important. You must begin with the minimum dose and rapidly mount up to large doses, without, at the same time, provoking any inflammatory disturbance capable of causing the glands to suppurate. Give Fowler's solution pure, or in conjunction with strychnia or nux vomica. Begin with ten drops, and in the course of a week increase to eighteen or twenty, giving the medicine before meals, and every fortnight give your patients a rest. In this way you will surely succeed in causing resolution and disappearance of these formidable swellings, whose ablation has almost always been followed by untoward results.

NOTE—The patient, who was the subject of this clinical lecture, was put on Fowler's solution Oct. 28, and the medicine was continued till Dec. 15. At this date, the tumefaction was so much diminished that it was scarcely perceptible to the sight; the glands were now separate from each other, and the patient was so well that he left the hospital. Two months afterwards he returned with the swelling as large as ever. The arsenical treatment was resumed, there was a new amelioration, and the patient again quit the hospital. We saw no more of him, but learned that he died in October of the following year; whether from the same or some other disease, we did not ascertain.—(Jan., 1888).

THE COMMON EYE AFFECTIONS OF ACQUIRED SYPHILIS.

BY EDWARD JACKSON, A. M., M. D.,
PROFESSOR OF DISEASES OF THE EYE IN THE PHILADELPHIA POLYCLINIC.

Three of the patients in attendance to-day very well illustrate the more common and more important of the lesions of the eye, that occur in the course of acquired syphilis. Occasionally the initial lesion does occur on the eye or eye-lid, but cases of such occurrence are rare. I have never seen one. And in general the first evidence of the disease presented by the eye is an iritis, appearing as one of the secondary symptoms, in from six weeks to two years after the initial lesion. The iritis generally comes on with the eruption, or as the eruption reaches its height. And the eruption may involve the skin of the lids, or the conjunctiva, just as it may involve any other free epithelial surface of the body. Here is our case of

Iritis.

J. M., aged 35, had a chancre about four months ago. For six weeks he has had this well-marked and characteristic eruption; and during that time he has been decidedly out of health, and has been under medical treatment, the exact nature of which we do not know. About three weeks ago his left eye got "sore;" that is, it became red, over-sensitive to light, there was excessive secretion of tears, and pain in the eye and in the neighboring brow and cheek, often very severe, especially at night. This condition continued growing, on the whole, rather worse; until he presented himself at the clinic, about ten days ago. At that time, you will remember, he complained of the symptoms just enumerated, and on inspecting the eye we found by oblique illumination that there was a zone of hyperemia surrounding the cornea; that the cornea presented opacities, but that its surface was smooth; that the iris was of a color slightly different from that of the healthy right eye, and that the pupil was slightly dilated, the latter condition being due to the use of an eye-water, which contained some mydriatic, though not enough of it to dilate the pupil properly. After the instillation of a solution of

Atropia sulphate.....1 grain
Water.....1 fluid drachm,

we found that the pupil dilated to almost the normal extent in every direction, except upward and inward, where there was a distinct projection or swelling of the iris. Opposite this projection of the iris there was a single spot of opacity on the anterior capsule of the lens where the pupillary margin of the swollen part of the iris had rested, prior to the dilatation of the pupil which had torn through this single adhesion. The corneal opacity mainly affected the lower portion of the cornea, and was situated near or upon the posterior surface of that membrane. In brief, we had here a case of iritis, mainly serous, but which had at one point become plastic; with well-marked punctate keratitis, and a history of recent syphilis.

There is a common impression that syphilitic iritis is always plastic, but it is often in the beginning serous, only there is no tendency to spontaneous recovery, and if not subjected to the proper line of treatment it runs on, almost invariably into a plastic inflammation, and often beyond this, to the formation of gummata in the iris. It is, on every account, important that the nature of the affection should be recognized, and the proper treatment inaugurated in the earliest stage, when a complete cure may be effected.

This man was put upon the one-sixth of a grain of calomel four times a day. When this had produced rather free purging, we tried the green or prot-iodide of mercury, but this in one-fourth grain doses, seeming to cause even more gastro-intestinal irritation, we returned to the use of the mild chloride, adding to each dose double its amount of powdered opium, which prevented any further diarrhea. This, the specific part of the treatment, has been continued up to the present time. We also gave at first quinia sulphate two grains three times a day, but this was discontinued as soon as improvement was well under way. Locally, he has used a solution of atropia sulphate, one-half the strength of that given above, three times daily; preceding each instillation, of one or two drops, by bathing the closed lids and the neighboring parts with water as hot as he can bear it. This local treatment will be continued; but as he is now markedly anemic we shall have him take internally, in place of the calomel,

Hydrarg. chlorid. corrosiv.....gr. ij
Tr. ferri chloridi.....f℥ iv

Fifteen drops, freely diluted with water, twenty minutes before each meal.

The eye is already free from hyperemia, and the dots of opacity at the posterior surface of the cornea are rapidly disappearing. Probably in two or three weeks the opacities will all be gone, and the only permanent mark of the disease of the eye will be the single speck of iris pigment left adherent to

the anterior capsule of the lens. Had the iritis become fairly plastic, with the formation of strong adhesions, recovery must have been much slower and less complete. But with the recovery of his eye he must not discontinue the specific treatment. Many months must elapse before he can be free from danger of another attack, or a similar invasion of the other eye. Syphilitic iritis is prone to affect both eyes, though often not at the same time, and by proper treatment the involvement of the second eye may be avoided.

Paralysis of the extra-ocular Muscles.

P. S., aged 55, came to the dispensary over two months ago, saying that for two weeks he had been suffering severe pain of an aching character in the right brow and temple, that he saw double, that he could not open the right eye, and that these symptoms, while appearing in the first place rather suddenly, continued to grow worse. On examination it was found that there was loss of power to raise the upper lid of the right eye, and inability to turn the eye up or down or toward the nose. If he looked at an object directly in front of him, or to the right, and about on a level with his eyes or a little below them, he saw it single. But on attempting to look in any other direction, the left eye moved properly, but the right, failing to make the attempted movements, paralytic squint occurred, causing the diplopia of which he complained. He had paralysis of the muscles supplied by the third cranial or oculo-motor nerve with pain referred to the ophthalmic division of the fifth nerve. Now, by far the most common cause of such a group of symptoms is a syphilitic new growth near the point where these nerves enter the orbit. We asked the patient about syphilis, but he denied ever having had it. We then inquired for rheumatism and other possible causes of such a lesion, but finding none fell back upon the probabilities of the case, and put the patient on the use of iodide of potassium, ordering

Potassium iodide.....1 ounce
Water, sufficient to make...1 fluid ounce,

each minim of this solution containing about one grain of the iodide. The advantage of such a solution is, that with it the dose can be so easily, accurately, and steadily increased. He took it well diluted with water, an hour or more after meals, at first ten drops three times a day, but increasing the dose every two or three days, until in a few days he was taking forty drops four times a day.

When the patient first applied, the paralysis of the superior, inferior, and internal recti, and of the elevator of the upper lid was almost complete, and three days later it was absolute. But, by the time he was taking one hundred and sixty grains of potassium iodide daily, improvement was quite noticeable, and although there were no symptoms of iodism, the dose was not afterterwards increased. The return of muscular power was first apparent in the elevator of the upper lid; the ptosis diminished rapidly. By the time he could, by an unaided effort of this muscle, uncover the whole of the cornea, there was some return of power in the superior and inferior recti; and a little later the internal rectus was able to turn the eye somewhat toward the nose. At the end of a month of treatment the drooping of the lid was entirely gone, and the eye could be moved quite freely, vertically or toward the nose, but there was still diplopia at the margins of the field of binocular vision in all directions except to the right, or a little upward and to the right. We now began to suspect what had before had been masked by the oculo-motor lesion, a paresis of the superior oblique muscle, supplied by the fourth cranial nerve. With the complete recovery of the third nerve, the weakness of the fourth became quite obvious, the double vision being, a few days ago confined to the lower right side of the binocular field, and the position of the false image varying as it would in such a condition. But this also was improving soon after it was discovered; and now, at the end of the seventh week, there is no diplopia, and the movements of the eye seem in all respects normal.

This patient's denial of any earlier manifestations of syphilis raises the question of our ability to diagnosticate the tertiary period, or sequellæ of syphilis, from the symptoms alone; and particularly by the tolerance of very large doses of potassium iodide. Perhaps we are not, by such evidence, justified in making the positive, unqualified statement that this man has had syphilis; but for all practical purposes of prognosis and therapeutics we may, in a case like this, consider the diagnosis settled.

Central Retinitis.

D. M., aged 42, had syphilis six years ago. The right eye has been lost by some general inflammation, leaving an occluded pupil, for which an iridectomy has been done without any practical benefit. He says that about seven months ago he first noticed a cloud before the left eye, the good one, which grew

denser day by day, and was most dense just in the direction that he attempted to look. He applied at one of the public clinics in the city, and received treatment under which his sight stopped getting worse, but there was no subsequent recovery of vision. He states that the drugs then employed included mercury to salivation, and potassium iodide to the amount of one hundred and sixty grains a day. During the months that have elapsed since he discontinued treatment, he thinks there has been no further change in his power of vision. When he first came here, two weeks ago, the appearances presented by this eye were precisely what they are now. Externally, we only notice that the pupil which presents one posterior synechia, seems a trifle large for a man of his age; and that when he attempts to see an object he does not look directly at it, but a little above or below it, or to one side; and in a somewhat prolonged effort to make out a letter on the test-card his eye roves all round it. With the ophthalmoscope, the retinal vessels, especially the arteries, seem rather smaller than is usual. The disk, besides being quite pale, is partially obscured by a faint gray cloud, through which the margins and the smaller vessels are seen quite indistinctly. Away from the disk the appearance of the fundus is normal, except in the region of the yellow spot. Here we see a grayish white area, irregularly oval, somewhat larger than the disk; and shading off into the normal fundus, in some directions abruptly, in others, very gradually. Some of the fine terminal branches that run in toward the fovea are buried in the mass which causes this appearance; and at no point is there any noticeable disturbance of the pigment layer. We cannot say that the choroid underlying this region is entirely normal; but so far as we can see, the morbid process is confined to the retina. And except that there was, probably, more hyperemia then, it is not likely that the appearances presented at the beginning of the attack were materially different from those we observe now.

Although there is every reason to think that this lesion was in its origin syphilitic; from his having undergone at competent hands a vigorous course of anti-syphilitic treatment, from the length of time that had elapsed since the original onset, and from the diminished vascularity of the affected parts; we concluded that the actual condition now to be dealt with was not a specific morbid process, but a process of atrophy of the nerve tissue, such as might follow any form of plastic inflammation of the optic nerve or retina. Acting on this view we ordered the use of strychnia, at first in doses of one twenty-fourth of a grain three times a day. The dose has already been increased to one-twentieth, and to-day we shall increase it to one-sixteenth of a grain. And having warned the patient to be on the lookout for any muscular soreness or twitchings, or stiffness about the neck or jaws, the first symptoms of poisoning by the drug, we shall continue from time to time to increase the dose until the occurrence of some of these symptoms warns us that the limit of tolerance has been reached. Already the patient says there is some improvement in his vision; and improvement is likely to be more marked and more rapid as the full physiological dose is approached. (Subsequently the dose was increased until it reached one-sixth of a grain three times a day, when slight evidence of the toxic action of the drug was noticed. Vision improved from $\frac{15}{200}$ to $\frac{15}{70}$, but remained entirely eccentric, the centre of the macula being still quite blind. There was, however, marked extension of the periphery of the visual field, and very considerable diminution of the central scotoma.)

Communications.

GRADUATED TENOTOMY IN THE TREATMENT OF INSUFFICIENCIES OF THE OCULAR MUSCLES. (STEVENS'S OPERATION.)[1]

BY CHARLES H. THOMAS, M.D.,
PHILADELPHIA.

The study of disorders of the ocular muscles in relation to functional nervous diseases has received a strong forward impetus during the past year, chiefly due to the published results of the labors in this direction of Dr. George T. Stevens, of New York, whose work on "Functional Nervous Diseases," recently published,[2] has challenged special attention, even where it has not met with entire approval. The subject occupies a standpoint on the line between the two important specialties of ophthalmology and neurology, it takes somewhat from both, and has already, by force of circumstances, become in a certain sense a specialty of itself. The operation and its application have, until recently remained to a remarkable degree personal in

[1] A paper read at the meeting of the Philadelphia County Medical Society, March 14, 1888.

[2] D. Appleton & Co., N. Y., 1887.

the hands of Dr. Stevens, notwithstanding that for many years he has reported it before medical societies and in the medical journals.[1]

All this, however, has been recently changed by the publication, within the last year, of his work above referred to, which has brought the method into such prominent notice, as to compel recognition. Other operators have now entered the field, among whom is Prof. A. L. Ranney, of New York City, who, as a neurological specialist, has reported[2] a series of cases of the gravest neuroses successfully treated by the Stevens's method. Beyond question a point has now been reached which shows the subject to be worthy of the most sincere investigation.

What I have to present to-night is, to a certain extent, in the nature of a preliminary report; as my work is necessarily incomplete in some particulars, owing chiefly to the considerable length of time required for observation to arrive at a just estimate of the permanency of the results obtained—especially in the gravest and, therefore, most important cases. I shall attempt to add little that is new to the presentation of the case as made by Dr. Stevens himself, and I cannot hope, in the length of time allotted for its consideration, to make a statement commensurate with its importance, but I have thought it right to rehearse briefly its principal features and to give my own experience in connection therewith, together with a sketch of a few of my own cases; because I have become convinced of the importance of the subject, and also because it has not, heretofore, been brought before this society—nor, so far as I can learn, before any other of the medical societies of Philadelphia. It is now about ten years ago that the operation was first brought to my notice by patients who had been under Dr. Stevens's care. It seemed to me incredible that results such as they claimed were produced in their cases, could have been derived from the cause assigned. Again, I questioned the practicability of performing the operation in the definitely graduated manner which was said to be practised by him. Under these circumstances, and in the absence of better information, my position was for a long time one of earnest opposition to the practice in question.

About three years ago, however, having under my care several cases of muscular asthenopia which I was unable to relieve, though I obtained the advice of several of the best known ophthalmologists, and being freshly reminded of the work of Dr. Stevens by a patient of unusual intelligence and reliability, who reported great relief obtained at his hands, I asked his assistance in the treatment of these cases. He kindly demonstrated to me, upon patients of his own, the practicability of the operation, and I became convinced of its great value. The results obtained were so satisfactory that since that time I have investigated the muscular as thoroughly as the refractive conditions in all cases coming under my care, and have as faithfully undertaken to correct them.

For the discovery of abnormality in any of the straight muscles, their physiological condition, both while at rest and in action, and in all states of the accommodation of the eye must be thoroughly understood. In order that binocular vision may result, the visual lines of both eyes must converge upon the same point, whatever may be the position and distance of the object. It is only under such circumstances that the rays of light are brought to a focus at corresponding points upon both retinæ. A slight deviation results in diplopia, constituting strabismus, a subject sufficiently well understood, and to which Stevens's researches do not directly apply. But while there may be perfect binocular vision, and not the slightest indication of strabismus, there may be, nevertheless, grave faults affecting the recti. It is these faults that Dr. Stevens has emphasized, and to these his observations have been chiefly confined.

In the normal condition of the ocular muscles the visual lines of both eyes naturally preserve an almost exactly parallel direction when looking at distant objects; and they maintain such a position of their own accord from muscular tonicity alone, without the necessity of any additional stimulus. This can be shown by prismatic tests. The artificial diplopia produced in making the test will be such that the two images will lie in that plane which is at right angles to the base of the prism.[1] If, for example, diplopia be induced by a prism placed before either eye with its base directed either outward or inward, the two images will lie in the same *horizontal* plane; and, similarly, *vertical* prisms, with base up or down, will induce

[1] See articles by Dr. George T. Stevens, on "Chorea" (*Medical Record*, 1876), on "Anomalies of the Ocular Muscles" (*Archives of Ophthalmology*, June, 1877.)

[2] "The Treatment of Functional Nervous Diseases by the Relief of Eye Strain," *New York Medical Journal*, January 7, 1888.

[1] Not that Dr. Stevens was by any means the first to employ prisms for the discovery of muscular irregularities, but he appears to have used them with greater precision and by more systematic methods than have heretofore prevailed.

diplopia; but in this case the two images will be situated in the same *vertical* plane. The reason for this is because the normal visual lines of both eyes naturally lie in the same *horizontal* and *vertical* planes, even when the powerful stimulus which the need of binocular vision presents is abolished by the prism. Hence, if the eyes in the normal state be directed to a distant object, binocular vision will occur without the need of extra muscular action to bring the visual lines to properly bear upon the object. If, on the other hand, the visual lines of the two eyes do not naturally take the proper position, one of the two things will result, either there will be no effort to bring them into correspondence, and strabismus with attending diplopia occurs, or, *more frequently*, by an extra nervo-muscular effort, called into action by the demand for binocular vision, the proper position will be maintained; just as in facultative hypermetropia accommodation is necessary even when parallel rays coming from a distant object are to be brought to a focus upon the retina. From this forced, though it may be involuntary or even unconscious effort to maintain the proper direction of the visual lines, the abnormal conditions under consideration result. We have abundant clinical evidence of the enormous expenditure of nerve force under these circumstances, and of the development of marked reflex disturbances, which are manifested both in symptoms of irritation and exhaustion.

Dr. Stevens has[1] introduced a series of terms descriptive of the various abnormalities to which the recti muscles are subject. The word *exophoria* designates simply an outward tendency of the visual lines, without implying anything as to which muscle or set of muscles is at fault. The opposite condition, namely, tendency to convergence, is designated by the word *esophoria*, meaning an inward tending.

If either visual line deviates above its fellow, the fact is expressed by the term *hyperphoria*, right or left, as the case may be, always remembering that the lower image represents the higher-tending visual line. It is to be remarked that the condition of hyperphoria is far more frequently productive of serious reflex disturbances than any other fault, and mainly for the reason that a small amount of deficiency in this direction may, and usually does, involve a considerable proportion of the total coördinating power of the vertical muscles; and this because the power of sursumduction is usually limited to about three degrees, while that of abduction is about eight degrees, and that of adduction may be fifty degrees and upward.

The generic term to express any deviation whatever from *orthophoria*, the normal, is *heterophoria*.

Finally, the amount of heterophoria found in any given case is equivalent to and expressed by the degree of the prism required to correct the fault.

In practice, the tests for insufficiency are made by placing prisms before the eyes with their bases in certain definite directions. Lateral diplopia is produced by a prism with base in, vertical diplopia by a prism either up or down. If in lateral diplopia so induced, either image is above the plane of its fellow, we know that the higher image belongs to the eye whose visual line is lowest, to be expressed as hyperphoria of the opposite eye. If, in induced vertical diplopia, either image deviates from the vertical, we have lateral fault—esophoria, if the diplopia be homonymous, exophoria, if crossed.

In applying the prism test for the discovery of muscular anomalies it is not sufficient to be content with the results of a single or even several examinations, because we must always bear in mind the possibility of latency—that is to say, like latent hyperopia, the true fault may be concealed or masked. Indeed, as in latent hypermetropia we sometimes have apparent myopia through spasm of the muscle of accommodation, so in actual esophoria an apparent exophoria may be manifest, the result of spasm of the externi, and this is equally true of the other muscles. It is only by a careful consideration of the circumstances, such as the degrees of abductive and adductive power; and, finally, by the use of temporary correcting prisms for whatever fault may be manifested, and following it up —but not leading it—as it develops, by a new correcting prism until the fault becomes stationary, that we are justified in proceeding to operation. In one obstinate case of exophoria I have several times obtained relaxation of spasm of the interni by a moderate dose of morphia administered hypodermically. But, though the after results proved the observation under morphia to be expressive of the true condition in this case, there are obvious objections to the use of the drug as a matter of ordinary practice. The discovery of an efficient and safe agent for the relaxation of spasm of the recti muscles is greatly to be desired. It sometimes happens that muscular anomalies of considerable de

[1] "A System of Terms relating to the Conditions of the Ocular Muscles known as 'Insufficiencies,'" by George T. Stevens, M.D., Ph.D. (*New York Medical Journal*, December 4, 1886).

gree are discovered in connection with refractive faults. By correcting the refractive error first not infrequently the muscular difficulty soon disappears, showing the muscular to have been dependent upon the refractive state. The correction of refractive errors, especially those of a hypermetropic character should always be made before applying the prismatic tests. Defects of refraction and accommodation are well known as the source of serious reflexes, especially headaches or severe migraine, nausea and dizziness; but it is not so well known that defects of muscular adjustment through faults of the guiding muscles of the eye produce all these and many more serious results besides.

From Dr. Stevens I quote:[1] "Respecting the importance to be attributed to ocular, refractive, and muscular anomalies, I fear that my views will for some time to come continue to be regarded as something more than radical; but I am ready to reaffirm the proposition made years ago, that, among the various elements constituting the neuropathic tendency, these anomalies must be regarded as occupying a preëminent position.

"Summing up the experience in this field of work, it is shown that, not in occasional and rare instances only, but in a large proportion of cases of the most redoubtable neuroses, unusual and most salutary results may be anticipated from attention directed to visual troubles."

Among the neuroses shown in many cases to be dependent upon such troubles, are to be mentioned neuralgia, spinal irritation and neurasthenia, chorea, epilepsy, and mental disorders. Dr. Stevens further says: "Not only are those painful or irregular conditions usually described as neuroses in great proportion responsive to the relief from ocular tensions, but a great variety of conditions commonly regarded as local affections yield as readily, and prove that with some possible local complications they are, in fact, reflex phenomena. As an instance of this class of trouble, I may mention the fact that in more than a score of cases of extreme dysmenorrhœa—in each of which the periodical suffering has been of intense character, of regular occurrence, and of the full duration of the menstrual life of the patient—the dysmenorrhœa has failed to occur after relief to the tension of a superior or inferior rectus."

"So far as my experience goes, epilepsy very rarely results from simple conditions. The ocular anomalies in epilepsy are of the most complicated, and often of the most obscure character. A simple insufficiency may induce headache or other minor manifestations, but the ocular causes of epilepsy are usually of a character most perplexing to the surgeon, and sometimes of a character which cannot be completely remedied. Hence, great patience, and, in certain cases, much time and skill are required to accomplish that which can finally be done. If, in the meantime, the patient and his friends are constantly assured by both lay and professional advisers that his efforts must, of necessity, prove fruitless, he is apt to withdraw from treatment, even while defects which are of great importance, are known to exist, and which, by continued efforts, might be removed."

Prof. Ranney is authority for the statement that in cases of epilepsy of long duration under treatment directed to ocular difficulties, the affection has been scarcely less tractable than diseases commonly regarded as easily curable. As furnishing a suggestion as to the possible method of production of epileptic attacks from eye-strain, it is interesting to note some experiments performed several years ago by Drs. Dercum, Parker and others in the artificial induction of convulsive seizures. They found that it was possible to produce spasms in many persons by the following method:[2]

"The subject being seated, the tips of the fingers of one or both hands were so placed upon the surface of a table as to give merely a delicate sense of contact—*i. e.*, the fingers were not allowed to rest upon the table, but were maintained, by a constant muscular effort, barely in contact with it. Any other position involving a like effort of constant muscular adjustment was found to be equally efficient. Any one object in the room was now selected, and the mind fixed upon it, or some subject of thought was taken up and unswervingly followed.

"After the lapse of a variable period of time, extending from a few minutes to an hour, and depending upon individual peculiarities to be noted, * * * * the subject was frequently thrown violently to the ground in a general convulsion, preceded by tremors which rapidly became more violent.

"Seizures equalling in violence a general convulsion were by no means induced in all subjects, and were generally the result of experiments repeated many times during the same evening. In the experimentors the con-

[1] See "Ocular Irritations and Nervous Disorders," by Dr. George T. Stevens. *N. Y. Medical Journal*, April 16, 1887.

[2] See "Artificial Induction of Convulsive Seizures," by Drs. F. X. Dercum and A. J. Parker. *Journal of Mental and Nervous Diseases*, October, 1884.

vulsions became so easily induced that it was thought advisable to desist for a long period."

The *effort of constant muscular adjustment* here spoken of appears not unlike the condition found in the eyes in cases of insufficiency of the ocular muscles; and it seems not unreasonable to infer that if such strain of the muscles of the forearm would produce results of the kind reported by the authors just named, that the strain upon ill-balanced ocular muscles (which must be continuous during the whole of the time that the eyes are opened) should be productive of even more serious, and, indeed, permanent results. In the great majority of these cases there is but one satisfactory method of treatment, and that is graduated tenotomy. The operation consists in making a small opening through the conjunctiva, exactly over the insertion of the tendon, when the tendon is seized by extremely fine forceps and divided outwardly in each direction, preserving the extreme outer fibres, or, at least, the reflection of the capsule of Tenon, which serves as an auxiliary attachment. Tenotomies for strabismus and so-called partial tenotomies have, of course, long been made, but there are radical differences between these and the operation here described. The fan-shaped expansion of the tendons of the recti at their points of insertion into the sclerotic are somewhat wider than is generally supposed, while the elasticity of their edges is an influential factor in determining a favorable result in the purpose of the operation—that is, in bringing about a relaxation which shall be permanent by permitting the divided portion to retract and form a new attachment to the globe further back.

The use of prisms as a means of treatment of marked heterophoria is not to be relied on; as in many cases they are found to be insufficient and disappointing.[1] They, however, have a certain value as means of systematic exercise of the ocular muscles, particularly in the milder cases. When the correction is made by tenotomy, all that is necessary to be done in a given case should be regarded, in a sense, as one operation, though it may be in several stages and at different periods—as a watchmaker counts the regulating of the watch one operation, though he may be obliged to move the regulator a number of times; or as the correction of an astigmatism is one operation, though it may involve a number of sittings.

In one complicated case I have operated as many as seven times; the first operation nearly two years, and the last a week ago; the net result being an unquestionable gain both in head symptoms, which were at one time alarming, and in the severe asthenopia to which the patient had long been subject. Previous to the operation she had suffered from severe pain in the region of the eyes and in the back of the head, accompanied by general nervous distress of an entirely disabling character. An eminent ophthalmologist declared her to have organic disease at the base of the brain from the appearance of the eye ground. This was about three years ago. To-day this lady assured me that she felt "wonderfully better," and expressed her entire satisfaction with the treatment she had received.

It is to be re-emphasized in this connection, as an additional caution, that no operation is ever to be undertaken unless the indications for it are positively made out. From a perfectly plain case, evident to the merest tyro, to one demanding the greatest skill and patience of the most experienced, there is every gradation. Nothing would tend more to bring discredit upon the procedure than premature operations, which might result in such disturbance of the ocular muscles as seriously to cripple binocular vision without in the least alleviating the reflex condition for which the operation was undertaken.

Mrs. G. H. C., referred to me by Dr. W. H. H. Githens, aged 32, married, mother of four children. Has suffered for many years from almost constant severe headache combined with a feeling of drowsiness, the seat of the pain being the brow and vertex. Eyeballs painful, always felt better when the eyes were closed. There is frequently double vision, but no manifest strabismus. General condition markedly neurasthenic. Although there was no error of refraction except a very slight amount of hyperopia shown only under full mydriasis, the patient was unable to use her eyes at any near work, such as reading, sewing, etc., and at all times suffers from extreme intolerance of light. Ophthalmoscopic examination negative.

Muscular tests. The first examination showed an esophoria of nine degrees, which, under the use of partially correcting prisms worn for ten days, developed into settled fault of twenty degrees of esophoria and twenty-eight degrees esophoria in accommodation. Tenotomy of the left internus relieved all the

[1] Since this paper was written a physician of this city—himself an accomplished neurologist—who habitually wears spectacles for the correction of refractive errors and who also suffers from muscular faults, in a conversation with me, said with emphasis, "It is *impossible* for me to wear prisms. I have tried them thoroughly and know they would drive me crazy."

BEFORE AND AFTER OPERATION UPON THE EYES.

BEFORE OPERATION.

ONE WEEK AFTER OPERATION.

[Prepared from the photographs exhibited by Dr. Charles H. Thomas to the Philadelphia County Medical Society. See *Medical and Surgical Reporter*, April 14, 1888, page 465.]

muscular fault except one degree, which I have allowed to remain. The relief of all symptoms was immediate and complete. The headache, the pain in the eyes, the intolerance of light, the drowsiness and double vision have all vanished. She is now able (without the aid of glasses) to read and sew as well as anyone, and threading a needle, which, previous to the operation, was almost an impossibility for her, is now done with facility. The general health and spirits have improved to a remarkable extent. The photographs in her case are from untouched negatives, taken under photographic conditions as nearly identical as possible. The first photograph accurately represents her condition at the time of the operation. The strained look of the eyes, and the high condition of nervous tension are in no way exaggerated. The second photograph was taken one week after the operation, though it might, indeed, have been taken a day afterward—the immediate relief was so great. Perhaps no change in her condition is more marked than that of her tone of voice, which, from being high-pitched, nervous, almost wailing in character, has been moderated, mellowed, and vastly improved. The photograph of this case gives a clearer idea than words can do of the change which may be wrought by operation —in her case a single operation.

As additional graphic illustration of what may be accomplished, I pass around a few photogravure proofs belonging to Dr. Stevens, which he has very kindly placed at my disposal.

J. H. W., thoroughly healthy boy, without any nervous symptoms whatever, has been under my oversight since infancy. Except for a chronic tarsal ophthalmia there was nothing to call attention to the eyes. Very slight hypermetropia, for which I had prescribed glasses several years ago. On examination, three months ago there were eleven degrees of esophoria manifest, for which an operation was performed, removing seven degrees of the fault. Two weeks later four degrees additional were manifested; a week later the total manifest esophoria was nine degrees, when a second operation was performed, resulting in the removal of eight degrees of nine then existing. A recent examination shows a manifest esophoria of three degrees, being a let-out of two degrees since the last operation.

From the first operation a marked change took place in his facial expression; his eyes, which had been previously almost closed, opened widely, the tarsal ophthalmia showed prompt improvement, and he expressed himself free from a constant struggle to keep the eyes from closing, which he had not recognized as dependent upon any condition of the eyes until after it had been relieved.

I present the patient this evening for the purpose of demonstrating the amount of setback given to the tendon, which, though invisible under ordinary circumstances, may be readily seen, upon causing either eye to be rolled outward, as a vertical line in each eye about two millimetres wide in one, and a little less in the other, where the sclerotic is plainly visible through the conjunctiva.

Whether the claim made that the neuropathic predisposition is more frequently due to eye strain than to other conditions is fully justified by the facts or not, it is unnecessary at present to determine; seeing that enough is known to make it certain that eye strain from muscular fault is the cause of grave and varied reflex neuroses; and that in these cases carefully graduated tenotomy promises relief; beside there is in such cases always sufficient justification for the sake of the eyes and sight—apart from the nervous condition —for the correction of the fault.

My own experience covers many of these operations, performed for the relief of a variety of conditions, and notwithstanding serious difficulties at times encountered, I have a steadily increasing confidence in the legitimacy and value of the method.

THE OINTMENT OF THE NITRATE OF MERCURY AS AN ABORTIFACIENT OF BOILS AND FELONS.

BY ROBERT C. KENNER, A.M., M.D.,

LOUISVILLE, KY.

For the last six years I have used the ointment of the nitrate of mercury as an abortifacient of boils and felons with a degree of success that has followed upon the use of no other agent for the same purpose. I have been able to abort nearly all the cases of boils and felons, which I saw before they had begun to suppurate. The application of the ointment is not painful, and in about twelve hours the pain disappears, and there is a peculiar "drawing" sensation which continues several hours, though it is not unpleasant, and then follows a complete cessation of all pain and uncomfortable sensations.

In describing my method of using the ointment of the nitrate of mercury for this purpose, let me detail several cases: J. J., a ferryman, came to my office complaining of pain in the forefinger of the right hand. It was red and hot, and caused him pain when he used

it. Increased tenderness was made out about one spot. He had suffered from felons before, he said, and was sure that this was an incipient one. I felt assured of this, and covered the entire finger with the ointment to the thickness of an eighth of an inch. I then put a piece of thick sticking-plaster around the finger, and had the edge of one side to overflap and adhere. The end was folded and sealed by thinner plaster. I then had him to put his arm in a sling, and instructed him not to take it out, or use it in any manner. I gave him a prescription for morphine granules, telling him to use them should his finger become very painful. The dressing was to remain on twenty-four hours, at the end of which time he was to report. He returned next morning, when the red, hot and painful condition which yesterday was evidently a developing felon, was now materially changed. The finger was pale, and it caused him no pain to make pressure on it. He said the pain had ceased about ten or twelve hours after the application of the ointment, and he did not have to use the morphine. I did not think further application of the ointment necessary, and he was allowed to go about his business, and suffered no recurrence.

S. B., applied for treatment for an incipient boil. She had one a short while before, which had gone to maturation, causing her much pain and annoyance, and she wished if possible to have this one aborted. It was on the wrist; it was red, painful and hard to the touch. The skin around was red and hot, but there was no evidence that any pus had yet formed. I applied the ointment over the boil and the adjacent red surfaces to the thickness of an eighth of an inch. She was instructed to take morphine granules if necessary, and to keep her arm in a sling, and to call at the office on the following morning. By this time, the boil, which before was beginning to assume its peculiar ovoid shape, and was hot, angry and red, had become pale, greatly diminished in size, and to a great extent absorbed. It seemed to be only a question of a short time for it to be entirely resolved, and I told her she might leave off the dressing when she went home. I had her to commence taking iron and quinine, and she not only had no further trouble from this boil, but was free from further recurrence of them.

In employing the ointment for this purpose to the neck, to the buttock, and several other parts of the body, the ingenuity of the physician will be called into play. The thick plaster which is to hold the ointment against the neck, may be held in place by small strips of thin adhesive plaster. But in warm weather, or in heated rooms, the ointment may become warm and run out from beneath the edges of the plaster. Especially is this likely to be the case, if the patient insists on going about his business. Much of this trouble can be avoided, by having the patient assume the recumbent position for the time. I insist on this as a necessary condition, and find few patients, who will not agree to accept it.

When there has been any formation of pus in the boil, the abortive powers of the ointment of the nitrate of mercury must not be depended upon, but I have frequently seen cases very favorably modified by it. When the boil has attained considerable size, and that peculiar place of softness, and often after the patient has felt the "throbbing and beating" which they describe, for several days, I generally conclude there is little or no hope of aborting it. Some cases will put us in doubt, and in these it is well to try the remedy. In one case I tried the remedy, when I felt there was little chance if any; and found while I did not abort it, that I had circumscribed the growth of the boil—and the annoyance which it produced subsequently, was greatly less than it otherwise would have been. But when the boil is large or very painful and we think pus is forming, it is not best to use the ointment. Poultices applied locally and anodynes internally should be relied on till the proper time to lance it has arrived. So, also with the felon; when we feel that the time has gone by when it might have been aborted, it is not advisable to use the ointment, because no good can come of it, and the pain which is generally agonizing will not be relieved to any extent. But if the inflammatory process has been essentially mild, the ointment may be tried in hope that it may still be cut short. But in those who come to us with the history of several sleepless nights, and unmistakable symptoms that lead us to believe that to temporize is to add to the patient's trouble, there can be no good result from delaying the free use of the knife, in hope of aborting a process now entirely beyond such a possibility.

The proper field for the use of this agent then is in the treatment of boils and felons which have not gone to such a degree of maturity in the one case, that pus has formed in its center, and in the other when we are sure the inflammatory condition has not gone beyond the primary and abortive stages.

This method of the abortive treatment of boils and felons is superior to several ways of treating boils and felons with this result in

view, in that it is easy of application—it is very simple, and unattended with pain.

DISEASES AND THEIR TREATMENT IN ARMENIA.

BY WILLIAM B. DEWEES, M.A., M.D.,
SALINA, KANSAS.

Some time ago I had the pleasure of listening to a very interesting lecture on "The Habits and Customs of the Native People of Armenia," delivered in a very pleasing manner, in English, by Mr. N. A. Morjickian, a native-born Armenian, who came to America about four years ago, unable to speak a word of English, or any other language except his native tongue. His object in coming to this country was to be educated in the literary and theological institutions of the United States, and afterwards to become a missionary, under the auspices of the Lutheran Church, among his own native people. He is at present pursuing his studies at the Denver University, Colorado. After the lecture I made his acquaintance, and found him very pleasant and interesting in conversation, giving evidence of being well informed on general topics of interest in this country. I finally asked if he would have any hesitancy in answering some questions relative to the diseases and their cure by his countrymen? He assured me he would take pleasure in responding, and the following letter may be of interest to the readers of the REPORTER:

"DENVER UNIVERSITY,
"Denver, Colorado, *Feb. 7, 1888.*
"*Dr. W. B. Dewees, Salina, Kansas.*

"DEAR FRIEND:—In reply, according to my promise, to your letter of inquiry regarding the diseases and their cure by the natives of my country—Armenia—I shall endeavor to give you a brief account. I will not repeat your queries, but will give the number in the order in your letter, and the answer to each respectively.

1. "*Cause of disease.*—The superstitious people attribute disease to the wickedness of the parents of the diseased one, and also to the diseased man's or woman's negligence of religious rites; but the more intelligent class attributes disease to the disorder of the organs of the body.

2. "*Medical education.*—Our physicians are not educated people; they consist of a class of wise old women who discover and classify, and treat diseases from observations.

3. "*Medical accomplishments.*—Inasmuch as they are not trained in medical science, they have no true accomplishments in that department. They must be of good reputation as to their moral condition.

4. "*Headache.*—This is cured by bleeding the nose or drawing some blood from the temples. No internal application or administration of anything.

5. "*Colic.*—I have seen dozens of times people suffering most intensely from colic and cured by the following: In a half cupful of water rub the horn of some kind of a serpent against a piece of stone harder than the horn; the water turns blue, and the diseased or sufferer drinks this liquid, and is cured. In recent years, brandy, made from mulberry fruit, is also largely used. Its effect is immediate.

6. "*Rheumatism.*—I never saw or heard of a case of rheumatism in Armenia; nor have they any knowledge of *neuralgia.* Opium is applied for toothache, though they are very little troubled with that. As a rule, they have very sound teeth. Why this is so I can not tell.

7. "*Lung diseases.*—A severe cold settled in the lungs is cured by sweating, as follows: Fill an earthen vase with water, close its mouth air-tight, put it in the oven, and boil it for quite a while. Bring the vase out of the oven and put it on one end of the boat-shaped tub, while the person afflicted with cold in lungs, is sitting down on the other end of said tub. The tub is in a very small and closed tent. The sick person now opens the mouth of the vase, and I tell you, Doctor, in about ten minutes the poor fellow is almost dissolved into dewdrops. He is now ready to come out, *but the grandma is not.* He is finally taken out and put in bed and almost smothered. That is the way they treat all for colds.

8. "*Child-birth.*—I suppose their manner of delivery coincides with that of this country as far as the position of mother, while the child is coming out of the womb is concerned. But our women do not suffer near half as much pain. They are not assisted by medical men. They generally have a grandma midwife. In a great many instances they give birth to the child while working in the field all alone. My aunt gave birth to a boy baby on the 7th day of August, while working in the harvest-field; she wrapped it up and walked home with it, a distance of about five miles; in less than a week she resumed her work on the field. I can recall a number of similar cases; so you see they are not confined to bed for any preparation or reparation.

9. "*Ague.*—The ague cures are quite simple and have always been to me interesting; they

are two in number. 1. Take a cup of strong vinegar and boil it; while boiling put in it two teaspoonfuls of pounded coffee and a half teaspoonful of pounded pepper; after these have settled, the diseased one, in the midst of the chills and shaking, drinks it all at once and as warm as he can swallow it, and the ague leaves him for good. I can bear an eye witness to this, having myself suffered very severely from the same disease, and being cured by this same remedy.

"The second method is by the plunging of the sick into cold water all at once. When the diseased is in the most intense degree of chills, calling for all the comforts or covers to be piled on him to keep him warm, then his friends take him by the hands and the legs and plunge him in a trough-full of cold water, and he is relieved.

10. "*Bleeding.*—This is done by cups, leeches and lancet; but leeches are in most frequent use. Leeches are kept for sale by our barbers, in coffee shops, in bottles filled with fresh water; that is, the water is changed every day. The Arabs also travel over the country in selling them.

11. "*Snake-bites.*—A snake bite is nothing uncommon in Armenia. As soon as a person is poisoned by a snake or some other poisonous animal or beast, the people catch a dozen or more frogs, cut them open and apply them one after the other in quick succession on the poisoned or bit spot. In case frogs are not convenient, chickens or lambs are killed and used in the same manner.

12. "*Hydrophobia.*—I cannot give a reliable answer to this, but I have seen tobacco used for the fresh bite of dog.

13. "*Hemorrhage.*—Salt water is the only remedy I can recall used to stop hemorrhage.

14. "*Freezing.*—I suppose you are aware that the climate is very severe in Armenia in winter, hence the cases of persons found frozen or almost so, are of common occurrence. You remember how the ten thousand Greeks froze to death in Armenia. When the person is only half frozen or frozen on his feet, he is put in a pile of cattle manure and kept there until he returns to his senses.

"I also remember seeing the juice of some kind of plant used for weak eyes and earache; also the root of some wild flower for moving bowels, but I cannot recall their names, nor have I seen them in this country.

"I hope these facts will be satisfactory, as all that I have mentioned are reliable and true.

"Thanking you for your kindness shown me while with you, and also for your kind invitation to your pleasant home, I am, with best wishes and kind remembrances,

"Sincerely yours,

"N. A. Morjickian."

Society Reports.

PHILADELPHIA COUNTY MEDICAL SOCIETY.

Stated Meeting, March 14, 1888.

The Vice-President, W. W. Keen, M.D., in the chair.

Dr. J. Madison Taylor, read a paper on the

Early Recognition of Exophthalmic Goitre (Graves' Disease).

In the paper which I have the honor to read to you to-night, I shall not attempt to do more than call your attention to the importance of early recognizing a disorder which often eludes one, to point out certain features which should enable us to do so, and to offer in illustration, very briefly, the salient points in half a score of cases.

Exophthalmic goitre, or Graves' disease, is not a rare malady. At first it is merely a disorder, but frequently becomes a serious disease, and is known to cause death. More often it unfits its victim for active usefulness, or, at least, limits this and sadly disfigures him. Like certain other ailments the outcome of irregular nervous discharge, what in its incipiency is a very manageable complaint, produces in time a disastrous effect upon the tissues, and forms a practically unconquerable disease. Dr. Jonathan Hutchinson says: "Graves' disease appears to me to be of the utmost importance, not only on its own account, but as what we might call a type malady. It is the most definite and striking example of which we know, of a severe and protracted malady which, despite its severity and persistence, yet has a natural tendency to recovery."

In reviewing a large number of cases in the search for a complete symptomatic picture, I find that the most constant early feature is sudden and marked evidence of loss of nervous equilibrium. The vaso-motor nerves seem quite unstrung. Hence arise flushing, sweating and other skin changes, diarrhœa and transient albuminuria. If at this time a careful watch be kept, I think we should find irregularities in the action of the pupil. The skin usually loses its healthy hue, grows sallow or dark, and becomes greasy to sight and touch. This oily look was present in

most of the cases I have seen, though I have not seen it mentioned elsewhere. Begbie recounts one case of pigmentation, or bronzing, of the skin; Reynaud calls attention to vitiligo; and Edward Squire, to a discoloration in an isolated instance. The oleaginous appearance seems to me quite constant on face and body. This grows less when salt sponging and belladonna form part of the treatment.

Gowers calls attention to muscular tremor. I have seen this rarely. In cases III and V there is a tremulousness in the voice, which I ascribe to nervousness; yet it is constant. The emotions become often so overwrought that various mental peculiarities excite apprehension. Or a wiser person may regard the case as one of pronounced hysteria; and, indeed, all through the malady hysteria remains present, more or less, leaving one not seldom in grave doubt. Frequently delusions occur, and these so closely in unison with the ordinary habits and thoughts of the individual as to render them most difficult of detection (see Case VI).

Dr. Hilton Fagge warns us to be on the lookout for "slight cases in which one or two of the cardinal symptoms may be absent throughout." Trousseau also insisted on this point. Von Graefe expresses the opinion that among women it is not rare to find instances of this malady where the only symptoms are disordered action of the heart, not accompanied by valvular trouble or hypertrophy, nor the faulty action of the lid as described by him.

Heart disturbance most often leads the sufferer first to seek medical advice. The pulse is always quick and irritable, usually intermittent. The heart-beats, as a rule, bear surprising relationships to the pulse. Overaction of the heart is well known to be a frequent feature of anæmia and chlorosis. Begbie thinks it a powerful factor in causing Graves' disease. Ross regards the anæmia which is usually present as rather a result. Throughout the whole vascular system there is a manifest lack of *tone*. So constant is this that it may yet be found competent to explain the causation of the disorder. Certainly the graver features bear causal relation to this state. The vaso-motor nerves seem all out of balance; nor can it be confined to one part, though the cervical sympathetic is most prominently involved. There are cases in which limited areas not governed by the upper ganglia show derangement, as in a woman now under the care of my friend, Dr. E. T. Bruen, where one side sweats from shoulder to toe, and the opposite eye is prominent. Arterial tension varies rapidly, and unaccountably; hence the oft complained of noises in the head, amounting at times to terrific roarings (as in Case V). This may explain the maniacal attacks, as well as blood-spitting, thirst, and transient albuminuria.

The heart itself is rarely diseased. The overaction in time brings on hypertrophy; more commonly, dilatation. It also suffers from the general malnutrition which is noticeable throughout the circulatory system. The small amount of structural damage which this viscus sustains is a matter for remark, however, when the profound functional disturbance is considered. Systolic bruits are commonly heard, even over the auricles and the great vessels of the neck. Dyspnœa is distressing. This at times, even early in the history, alarms one who feels naught else to complain of. The thyroid enlargement is liable to appear long before the eyes become prominent, but readily escapes attention. It may happen that a sense of constriction is felt when swallowing, especially in men who wear tightly fitting collars. Both lobes are, as a rule, enlarged; but if only one, it is generally the right. When recovery takes place, this badge remains to chronicle the victory.

The eye prominence is late to appear, as a rule, and it would seem to mark the height of the disorder. Before the exophthalmos, there may generally be noted the sign asserted by von Graefe to be pathognomonic, a belated action of the lid in following a downward movement of the ball. Sometimes the lower lid is tardy in following an up glance. This obtrusion of the eyeball is the most picturesque feature, but happily it is not constant, and is often very late. It is of both eyes, mostly, but if of only one, again the right suffers. Sight is seldom affected, except where the outstanding, unprotected cornea suffers hurt or irritation; then opacities may result. If errors of accommodation exist, this correction, in my opinion, greatly aids in reducing the exophthalmos. Fundus lesions are not characteristic; though pulsation of retinal vessels may serve to confirm suspicions.

Knee-jerks are rarely abnormal; often in slight excess. Electrical examination has been, very recently, shown by Charcot, and confirmed by Vigoroux and Norris Wolfenden, to aid greatly in fortelling the onset of this trouble, the bodily resistance being greatly lessened most peculiarly in this disease. This may prove a valuable aid in diagnosis.

Case I.—This illustrates extremely well the more distinctive features other than

exophthalmos, which is not present—especially the marked vaso-motor disturbance.

Jennie H., aged twenty-three years, single; no neurotic history, intelligent, hopeful temperament; somewhat emotional and talkative. Vague history of a fall at two and a half years, followed by a convulsion, and, from time to time, "fits" are described, but not clearly. At first they seem to have been epileptiform, but later resemble emotional overflow. At fourteen years had typhoid fever, and for twelve months was "weakly." Some swelling of the limbs noticed—then came a period of good health. At seventeen years menstruated first, but not regularly for a year or more. At nineteen years began to work in a shoe factory, in a very exposed room, excessively cold in winter; frequently sat in wet shoes all day long. At twenty years, after a very painful day from cold, walked home in slush, profoundly exhausted; soaked her feet in hot water and went to bed. Then followed a nervous chill with throbbing pain at heart—it beat rapidly; an overwhelming sense of suffocation arose. From that moment the heart has been disordered. Then followed a series of medical pilgrimages to different dispensaries, with small benefit.

I think many of her symptoms were, even then, hysterical, masking effectually her real trouble. She had hæmoptysis, cough, great emaciation, and was treated for phthisis. The fits brought her under treatment for epilepsy. So far as I can learn, no one noticed anything amiss with the eyes or neck. I think there has been at no time exophthalmos, but a peculiar fluctuation in the condition of the pupils, which I infer is not recent. The dyspnœa grew worse steadily, till it became impossible to lie in bed; and for six or eight months she slept fitfully propped up in a chair. In May last a profuse blood-spitting prostrated her for four weeks; soon after the urine was suppressed for three days, with no pain—then a very dark, thick, offensive fluid passed. During the past summer was very weak and thin, but attempted repeatedly to work. Over-exertion at the wash-tub bowled her over again; several hemorrhages followed, and on October 1 she applied to me at the Howard Hospital.

I found a very pale, thin woman, suffering great dyspnœa; respiration 24; pulse fairly regular, 130 to 135; coughing incessantly; carotids throbbing wildly; pupils widely dilated; von Graefe's sign absent. There was complete mydriasis, as we found later, but no fundus lesion. The heart was laboring, loud musical murmur over base; apex beat downward and outward; *bruit de diable* in vessels of neck; thyroid gland enlarged, especially to right side, conveying thrill to hand; neck fourteen and three-quarters inches; skin pale and oily looking, readily sweated, and became chilly; legs œdematous; menstruation had been absent for three years; bowels always loose; urine, small amount, bright red with blood; sp. gr. 1.009; no casts; knee-jerks excessive in both legs; station bad from weakness.

Treatment.—The treatment consisted of carefully regulated feeding and rest; to drink plentifully of flaxseed tea; iron, in form of Basham's mixture, and digitalis, and hot hip-baths; belladonna plasters to the over-excited heart; later, cod oil and bromides, with digitalis. In a week the pupils became responsive to light; cough greatly moderated; the urine only smoky; heart sounds more defined.

To be brief, in two months the cough ceased; she could lie comfortably in bed; ate well and slept well; pupils became normal; had two or three "spells"—a little scolding aided these. In six months the girl pronounced herself cured, but she is readily upset by trivialities; twice the pupils have widely dilated on catching a slight cold, and once recently the urine showed traces of albumin. The menstruation was established twice, and slight showing at other times. She can now work at house chores with small fatigue. Pulse about 85 to 95, when standing.

Case II.—Mrs. H., aged about twenty-eight, no neurotic history, two living children, came under my care in 1881 during a miscarriage with adherent placenta. A similar disaster had occurred also some months before. My attention was drawn to a most disfiguring degree of exophthalmos. This had been observed within a few months by a well-known physician, who also warned her that she could scarcely hope again to bear a living child—probably on account of the disorder thus indicated. There was then menstrual derangement and great dyspnœa. Digitalis and ergot were ordered, also care to avoid exertion, but no clearly defined schedule of living. This I supplied and rigidly enforced—insisting upon systematic feeding and rest. I also found an irritable pulse and temper, muffled heart sounds, etc., but very slight right thyroid enlargement, a markedly livid oily skin, sweating surface, loose bowels, and occasional albuminuria.

Under treatment consisting, as stated, of regulated living, digitalis, ergot, along with iron and other tonics, she steadily improved,

till in seven or eight months there remained only dusky skin and the eye and lid symptoms. These last I felt sure would improve under use of glasses rightly adjusted—she having a high degree of myopia. After some persuasion this was accomplished with most admirable results, for the exophthalmos materially lessened thereafter.

I may say, as a matter of interest, that I have since delivered this woman of three healthy children at term, each of which she suckled for a full year, and that she now enjoys excellent health. There is no heart trouble, no goitre.

Case III. Graves' disease; obscure and abrupt cause; extreme nervousness, cardiac distress; death. No autopsy permitted.—Mrs. S., aged thirty-six, no neurotic history, one child. Two years ago she seemed in perfect health, weighed one hundred and sixty pounds. Happily married, surrounded by every luxury and loving care. Sustained no shock, no fright or exhausting disease. Fell into the hands of gynecologists, who found displacements and tears, and repaired these, as it proved none too well. While sitting in perfect health at a theatre, not in the least excited or especially interested in the play, she suffered a nervous chill, and from that time the disorder rapidly grew. The chills frequently recurred, changing to what she described as "waves of feeling up and down the body;" on the slightest exertion sense of constriction in chest, and skin broke into a sweat. Afraid to step about the room. Bowels loose, slept badly, lying awake for hours feeling afraid. The disorder was not recognized.

Sent to Dr. Weir Mitchell with a description of "neurasthenia and heart disease," and through his courtesy I was allowed to see her repeatedly. She was a very excitable, nervous woman, rather thin, weighing one hundred and ten pounds, with a frightened, restless expression. Eyes slightly prominent, some little slowness of upper lid, injection of cornea, tremor in voice, tremulousness of hands on movement, constantly plucking at bed-clothes or handkerchief, or arranging her hair or dress; throbbing carotids, pulse of 125 to 135 lying, and very irregular, loud musical murmur, etc. Bronzed, glistening skin, chilly hands and feet, sweats readily, etc. Thyroid enlarged almost symmetrically, conveying thrill to the hand. Some improvement under rest and tonics. Another operation was found necessary, and though slight, she sank and died. No autopsy allowed.

Case IV. Graves' disease; slight exophthalmos; slight thyroid enlargement; cardiac disturbance; delusions and rapid loss of flesh; caused probably by exhaustion from bearing ten children, and precipitated by sharp dysentery; recovery.—(By permission of Dr. Weir Mitchell and partly under my care.) Mrs. J., aged thirty-nine years, family history good, most favorable surroundings; ten children; began a year ago to lose flesh rapidly during severe dysentery; appetite very poor since. Slight delusions; vertigo. Eyes only noticeably prominent; corneal vessels injected; restless expression; slight tremor; skin clammy and glistening; dyspnœa. Thyroid enlarged a little; heart noisy; no valve defect; very emotional; albumin and muco-pus in urine. Under tonics and rest gained steadily. Referred to me at seashore in summer; rapidly picked up flesh and strength there; gained forty pounds. Now describes herself as being in good health.

Case V. Graves' disease; slight exophthalmos; slight thyroid enlargement; cardiac disturbance and tremor; marked improvement.—Miss R., aged twenty-five, family history good. At ten years had typhoid fever, at eleven very severe dysentery; long in regaining strength; much headache at nineteen years, an illness began by neuralgia in face and marked prostration; noticed rapid breathing; soon eyes were remarked as being "curious looking;" tried to gain strength by exercise in open air. In 1881 again fell ill. In March, 1882, consulted Dr. Seguin, who pronounced unfavorably; at that time had much œdema in legs; ordered digitalis; quiet. Following November grew much better; partly in bed for several months. December, 1883, she saw another physician, who relieved the increasing diarrhœa. May, 1881, to May, 1884, menstruated only once; thence irregular till a year ago, since then fairly regular. Weight about one hundred and thirty-five; skin moist and shiny; beads of sweat on upper lip; tremulous lip and tremor in voice, this seems a constant feature; at times tremor in muscles elsewhere. Exophthalmos slight; von Graefe's sign in both eyes; pupils normal; corneal vessels injected; flushes readily; not pale; heart tumultuous; no valve defect; pulse intermittent, one beat in three or seven, very difficult to count. Thyroid enlarged symmetrically; well-marked thrill; loud bruit in right neck; buzzing in head; sweats almost constantly; respiration 28, sighing; dyspnœa great on slight exertion; cannot lie in bed at night; bowels loose.

Rapidly improved in most respects under treatment by regulated living, digitalis, and

belladonna; tonics, iron, etc.; salt sponging; hot hip baths; menstruation more comfortable. In January had an attack of nervousness at night time, sense of great pressure in head and flashes of heat over body; ringing in ears. Eyes were examined by Dr. de Schweinitz, who found slight hypermetropic astigmatism; no fundus lesion. Alternate hot and cold water to nape of neck relieved the sounds in head. Is steadily impoving to date.

Case VI.—Miss D., aged twenty-four, family history decidedly neurotic. Mother "queer." At one year scarlet fever followed by "water on the brain;" soon recovered good health. Menstruated at fifteen.

August, 1885. Dysentery.

December, 1885. Heart began to alarm her. Vertigo sitting or walking; grew weak, short of breath, and extremely nervous; could not sleep, began to groan loudly in sleep, which continued till recently. Skin itches intolerably; sweats rapidly on exertion. Roaring noises in the head. Legs swelled, also feet—"the buttons were burst from the shoes."

March, 1886. Neck enlarged. In May the eyes started forward. Appearance: Eyes very prominent, sclerotic shows half an inch or more above and below; lids puffed, corneal vessels injected, face bloated and livid; skin greasy. Thyroid enlarged in three directions, most on the right; neck thirteen and three-quarter inches. Heart sounds clear; impulse heaving; slight systolic whirr. Pulse regular, 112 standing. Bowels very loose; tremulous voice. Eyes examined by Dr. Hansell, show some accommodative defects, but no fundus lesion. Urine albuminous. Decided delusions. No improvement.

Case VII.—Miss M. D., sister to above, well-grown girl, well till a year ago, when she had "walking typhoid"; afterward very weak; fainting spells; vertigo on walking; sweats readily; constantly chilly, especially the hands and feet. Buzzing in the ears. Menstruated at thirteen, but it is extremely irregular, rarely lasting over two days. Eyes showed no lid sign; no exophthalmos. Thyroid enlargement right; neck twelve and three-quarters inches. Heart quick and feeble; muffled sounds, roaring noise over the right clavicle and through the thyroid, also marked thrill. Carotids pulsating visibly. Pulse, 128 to 130. Very pale. Is improving.

Case VIII.—Mrs. S., aged forty-six; mother living, a "fidgety" woman, has two children. Fairly good health till 1881, when she had typhoid fever, followed by large abscess in the abdomen, opened in two places. Treated in the Jewish Hospital. After this shortness of breath began. In 1881 a financial blow greatly worried her; she would sit and brood over her troubles, then the fever. Exophthalmos began, along with diarrhœa; sweated a great deal on both sides. Buzzing in the ears. Appearance: Strongly built woman, weight 130 pounds; skin muddy and dusky. Left eye very prominent, right less so; lid signs of both eyes. Carotids throb moderately. Heart sounds clear and distinct; slight bruit. Has been under treatment for eight or nine months. Digitalis and iron and belladonna. Dyspnœa greatest on cold days. Urine at times profuse; no albumin. Œdema of legs fluctuates. Is steadily recovering, though susceptible to fatigue, cold, and shocks.

I hope to discuss the treatment, on which I have some decided opinions, on another occasion. This consists mainly of rest, judicious feeding, tonics, and carefully selected sedative measures.

Competent glasses, too, are essential; at times sharp counter-irritation; especially diuretic remedies and attention to the emunctories. Galvanism, too, has immense value in some instances, but requires judgment in selection of cases.

In brief, whatever measures tend to repair the tone of the vascular system, and allay nervous excitability will best bring about gratifying results.

In opening the discussion Dr. S. D. Risley said: I would like to ask Dr. Taylor whether there is any indication by which the development of exophthalmos can be expected in cases in which it has not yet appeared.

Dr. J. B. Roberts: I believe that the great ocular deformity which is so unpleasant to the patient, and attracts so much attention, can be remedied by a very simple operation: merely putting a stitch at the outer canthus, after freshening the edges of the lids, to diminish the optic commissure after the case has made such progress that it is reasonably certain there is to be no further diminution of the prominence of the eyeballs. The patient can be made more comfortable and less conspicuous.

Dr. Edward Jackson: The procedure suggested by Dr. Roberts might be resorted to for other than cosmetic reasons. I recently saw a case of this disease with very great exophthalmos, in which one eye had been lost through sloughing of the cornea due to exposure; and I afterward learned that the second eye had been lost in the same way.

Such an accident might be prevented by narrowing the fissure of the lids.

Dr. A. V. Meigs: I know of one person who has completely recovered from this disease, a woman who had a very severe attack many years ago, under the care of my father. The prominence of the eyes, which was very great, is now hardly noticeable, and yet no operation was ever done. I do not think much would be gained by sewing up the canthus, for while the disease is in its acute stage, it is hardly likely the operation would afford much relief, and later, if the patient recovers at all, the difficulty cures itself. I think I know the case Dr. Roberts had in his mind when he spoke, and Dr. de Schweinitz, who has seen the woman in question, will probably agree with me that nothing would be gained by an operation. One thing I have learned of recent years, and it is that it is not necessary in all cases to put the patient in bed. I could mention three or four cases I have successfully treated with tonics and proper regimen, without its becoming necessary to have rest in bed; the cases, to be sure, were not severe. Dr. Taylor speaks of the early recognition of the disease. For my own part, I do not see how a positive diagnosis can be made until we have at least two of the features of the disease present, namely, the cardiac palpitation and some thyroid enlargement; the prominence of the eyes occasionally does not manifest itself, but a diagnosis can undoubtedly be made in its absence.

Dr. G. E. de Schweinitz: I have examined the case that Dr. Meigs refers to, and I saw nothing to be gained by surgery. The eyes were at first very prominent, but they were then receding, and now the normal relation of lids to eyeballs is restored. Inasmuch as there was considerable myopia, and hence the not uncommon prominence of myopic eyes to begin with, they will always be more or less conspicuous.

Dr. S. Solis-Cohen: I have been extremely interested in this valuable paper of Dr. Taylor's, the more so that I think I recognize in his first case a patient whom I have seen, but in whom I did not recognize this disease. She was treated at the Jefferson Hospital some three years ago for anæmia, and was apparently cured. A year ago she returned with the history of "fits" spoken of by Dr. Taylor, and was irregular in attendance and unreliable in statement; the hysterical element so noticeable, probably preventing the careful investigation the case should have received. I consider it the more remarkable that thyroid enlargement should have escaped notice at the clinic in this case, as the comparatively frequent discovery of it at one time, in cases of cardiac and vaso-motor disturbance, has put all the clinical assistants on the lookout for the phenomenon. I can thoroughly agree with Dr. Taylor that vaso-motor paresis plays an important part in the development, if not in the genesis, of this disease. The only case I have seen in the male subject occurred in a young man subject to frequent attacks of flushing of the face, sometimes accompanied with high temperature, in whom the rapidity of the heart's action had led to a diagnosis of hypertrophy of the heart, not warranted by physical exploration. The eyes were not involved at the last time I saw the patient, nor was thyroid enlargement sufficient to attract attention without special examination. I have now under my care in private practice a young lady not at all hysterical, subject to similar attacks of flushing which sometimes leave behind for a short time wheals like those of urticaria. She has also had two attacks of sudden transient blindness, after which all that could be detected in the fundus was moderate congestion. This patient's cardiac action, rapid and irregular at these times, is at other times perfectly normal. No organic lesion of any kind has been detected either by me or by more competent observers. It is possible that this may be an early stage of Graves' disease. Improvement has taken place under minute doses of picrotoxin, a drug which Dr. Bartholow has prescribed in cases of exophthalmic goitre, at the hospital, with very good results. One case especially I recall which was associated with purpura. I would like to know whether Dr. Taylor has met with this association. A very interesting case of acute exophthalmic goitre presented at the clinic, which Dr. J. C. Wilson may remember as the subject of one of his clinical lectures: an anæmic young girl affected from childhood with nystagmus, in whom goitre and exophthalmos were asserted to have developed within a short time after a fall from a ladder. She was unable to button her collar, which friends had opened in attending to her after the accident.

Dr. J. C. Wilson recalled the case mentioned by Dr. Cohen, but not with sufficient distinctness to add anything of importance to the account already given. Dr. Wilson briefly narrated two cases of Graves' disease, recently seen in his private practice, in which the symptoms developed rapidly after mental shock. The patients were young women. The first, a servant, aged twenty-four, of previous good character, was engaged to be married to a young man who was by occupation the driver of an ice cart. Within a day

or two of a visit to her, he was accidentally killed, and her first knowledge of his death came through the newspapers. Cardiac overaction at once developed, and within a month thyroid enlargement, and slight exophthalmos. Under rest and large doses of Fowler's solution complete recovery took place in a year. The second case was that of a lady, aged twenty, who rapidly developed the characteristic symptoms of Graves' disease after the shock and grief occasioned by the disappearance of a near and loved relative, and the discovery that he was a defaulter to a very large extent. The prominence of the eyeballs was in this case very slight; the other symptoms were characteristic. Under treatment by rest and arsenic decided improvement took place. It is now a month since she last reported.

Dr. Taylor: In reply to Dr. Risley's query, Does any sign clearly foreshadow the exophthalmos? I can only say that I know of none, nor did I see anything in the literature of the subject to aid us. It usually marks the height of the disorder, though this may be the first feature noticed, especially when it arises suddenly as from shock or overwrought emotion.

To Dr. Meigs' objection that the three classical symptoms can alone and in conjunction constitute the disease, I can only say that it seems to me readily possible to recognize in the peculiar vaso-motor disturbances the extreme and unaccountable nervous excitability, the appearances of the skin, etc., the early stages of this disorder. In fact, the object of my paper was to call attention to this very possibility, so that a quietus might be placed upon it at the very beginning, if possible.

In the use of galvanism we have a valuable aid in diagnosis, as Charcot and Vigoroux have pointed out, but in the treatment it has not been of greater use than some other measures, though it should always be used in the severer cases. Many of my own patients live out of town, but upon those in reach I use it.

In my endeavor to be brief I did not intend to say much on plans of treatment, leaving that for consideration elsewhere, but rather to speak of early recognition and *early* treatment, which should consist of rest, carefully regulated living, food, and tonics.

In opening the discussion, Dr. Thomas's paper on

Graduated Tenotomy in the Treatment of Insufficiencies of the Ocular Muscles (Stevens's Operation),[1]

Dr. H. F. Hansell said: I would like to ask Dr. Thomas for a more definite statement as to the means of diagnosis. To my mind these are not at all satisfactory. The recognition and the exact determination of superior and inferior insufficiences are very difficult, much more so, than of lateral defects.

Dr. B. Alex. Randall: I have for years taken great interest in the subject of muscular insufficiency, the more so because I have myself been troubled with a defect of the kind, which Dr. Risley corrected for me ten years ago; and with his kind aid, and independently, I have been studying the matter since. As to diagnosis, much has been written, sometimes pretty wide of the mark; and I cannot see that Dr. Stevens has improved our methods. He has brought forward a very nice set of terms for what we have long known, and he has expressed clear-cut opinions which read well. In the same way, Landolt makes out very pretty graphic charts of cases, and marks out well defined groups, which are to be treated according to certain rules. But the cases which I meet in practice refuse very often to be included in such categories, and very dissimilar cases afford discouragingly similar charts.

I understand from Dr. Thomas's paper that the estimation of defects is largely made with a distant object, presumably a light at twenty feet. To do this we must know the refraction and the accommodation, and I suppose that these are investigated as a matter of course. But it is not safe to take the accommodation for granted. I can myself change my exophoria to apparent esophoria by the accommodative effort, so-called; and every patient may as readily do the same.

As to correction by operation, I cannot speak like Dr. Thomas from personal experience. We all know that when a certain degree of error is reached it is necessary to operate, and Dr. Stevens places that point very low. His method of operating is highly praised as a delicate one, but the necessity of dividing the operation into many steps is rather unfortunate. However, if he can thus relieve epilepsy, that minor disadvantage may be overlooked. It may be said in conclusion, that except in pointing out that *hyperphoria* is a frequent cause of perplexing and irregular insufficiencies of the lateral muscles (?), Dr. Stevens has added little to our knowledge of the nature of these affections; that in his claims as to their importance, he has gone much further than the experience of equally competent and diligent investigators has enabled them to confirm him; and that in his operative treatment he has merely developed a refinement of the partial tenotomy long in

[1] See page 460.

use, as the only means of correcting without overdoing it, the minute deviations from the perfect balance which he deems worthy of operative interference.

Dr. Thomas: Lack of time prevented me from treating at length in the paper of the points as to diagnosis which have been made the subject of questions. There is a variability, and yet, after all, a certainty in these tests which comes as the result of practice and observation. There is an irregularity in the results of the tests from day to day, but after getting the extreme limits of the swing and studying all the circumstances of the case, one is able to strike an average which very fairly represents the error to be corrected. Then a prism is temporarily adjusted to compensate for this error; and thus we make a crucial experiment and are further guided by the effects obtained. A lighted candle at twenty feet, and the dot and line of von Graefe at reading distance, are *both* to be employed as test objects, and a comparative study should be made of the results obtained—both in the absence and in the presence of accommodation. In this way we frequently get important clews. Sometimes anomalies appear in the action of the lateral muscles comparing the tests at reading distance with those at twenty feet; and when great erraticism of this sort is shown, we may be pretty sure in the majority of cases that we shall in the end find a manifested hyperphoria. Unfortunately, there is no known analogue of the mydriatics which we can well use in these cases, and yet with great patience and watchfulness we shall usually succeed. My results are hopeful in epilepsy, but my operations are too recent to speak positively of cure.

In reply to a question by Dr. Osler, Dr. Thomas said that he had not as yet met with any case of chorea suitable for the operation.

Hospital Notes.

PHILADELPHIA LYING-IN CHARITY.

TREATMENT OF MAMMARY ABSCESS.

Reported by Chas. P. Noble, M.D., Senior Assistant Physician.

From the therapeutic standpoint, mammary abscesses may be divided into those of recent formation and those of longer duration. The treatment of recent cases, those in which the abscess has not discharged, is similar, whether sub-dermal, parenchymatous or sub-mammary. The sub-dermal abscesses, usually connected with Montgomery's glands, are generally trivial, and would doubtless heal after incision without special precaution. It is more than questionable whether sub-mammary abscesses are not simply parenchymatous abscesses where the pus has burrowed posteriorly in seeking an outlet. So that practically we have the parenchymatous abscess to deal with. The indications are to evacuate the pus and promote the healing of the cavity. These are met by an incision sufficient for drainage, with the antiseptic dressing. The incision and manipulations are so painful that ether is required. The service at the Charity has afforded but few cases of this class, and these, with but one exception, were outside cases. This woman was syphilitic and septic. In the maternity wards strict prophylaxis is maintained, with the above happy result. The operation is done as follows: After etherization, the breast and surrounding parts are scrubbed with soap and water, and then disinfected with sublimate solution (1–2000). A radial incision one-half inch long is made down to the abscess. If the amount of pus is small, and seems to be thoroughly evacuated, the cavity is irrigated with the sublimate solution and the dressing applied. Otherwise the finger is introduced, neighboring abscesses, if any, are opened, necrotic septa broken down, and the necrotic masses thoroughly removed by irrigation. Large cavities with communicating sinuses are packed with sublimate gauze; in moderate sized cavities the drainage-tube is used. The dressing consists of sublimate gauze, absorbent cotton and the roller bandage. In the milder cases redressing is not practiced for several days, without special indications; in the others, after twenty-four or thirty-six hours. Then the packing is removed, irrigation practiced, the tube or a smaller amount of gauze inserted, and the dressings reapplied. The process is repeated when the discharges soak through the dressings. Healing has been rapid and without incident.

In the cases of longer duration the condition is usually one of mammary fistulæ with recurrent abscess formation. The so-called pyogenic membrane is present. Several cases with extensive sloughing (one during pregnancy) have been under care. The same operative technique is observed. The incision, or incisions, are frequently extensive, the radial direction being observed as nearly as possible to avoid cutting across the milk-ducts. The neighboring abscesses are carefully opened; the partition walls broken down with the finger, or incised; the walls of the sinuses and abscesses scraped with the finger or cu-

rette; and the whole disinfected with sublimate solution, and the detritus removed with the irrigator. The operation is sometimes extensive, and the amount of blood lost considerable. In these cases sutures are introduced whenever primary union can be gotten or contraction favored. Equable pressure, secured by cotton and the bandage, greatly favors closure of these cavities. The drainage-tube and gauze packing are used, and the after-treatment is similar to that described. In no case has there been a failure to obtain a cure, in some brilliant results were attained, and in general the healing process was steady and progressive. In some cases granulation was stimulated by the occasional use of silver nitrate. Sublimate irrigation favors granulation. Nursing from the affected breast is suspended, and the patient confined to bed until the healing process is far advanced. The essentials aimed at in this method are thorough opening and evacuation of all pus sacs, thorough drainage, and thorough antisepsis, together with the enforcement of perfect rest. The method is based on that of Billroth, and is, indeed, but the application of general surgical and Listerian principles.

Periscope.

Anomalies of the Genital Organs in Idiots and Epileptics.

In the *Progrès Médical*, February 18, 1888, Bourneville and Sollier communicate the results of their personal study of the genital organs of 728 idiots, or epileptics who were more or less imbecile or demented. They give elaborate tabulated statements of these cases, and sum up the results of their observations in the following statements:

1. In the first place, it is obvious that idiots and debilitated epileptics present anomalies with extreme frequency as compared with sane people. 2. Those who have become epileptic at a certain age, and after being partially developed, present much fewer anomalies than the simple idiots. Their genesic functions, unhappily, seem less affected than in the latter, if one may judge by the fewer number of cases of concealed testicle. 3. Atrophy of the testicle seems to affect the right side nearly as frequently as the left, although it is a little more frequent on the latter—a statement which confirms the general opinion of authors. 4. The physical and intellectual degeneracy produced by epilepsy seems to have a definite influence upon the production of varicocele, for idiots who are non-epileptic, do not, so to say, present it. 5. When epilepsy seizes upon a child at the beginning of its life, it produces throughout its being an arrest of development which is much more marked than when epilepsy occurs in adolescence, and this arrest of development, while appreciable upon the whole of the individual, is most characteristic in the genital organs. 6. Idiots, epileptic or non-epileptic, frequently present a particular form of the penis, called bell-clapper or club-like. This shape is not acquired by masturbation, as certain of those who present it have never been addicted to masturbation.

The Etiology of Phthisis.

Dr. R. W. Philip, Physician to the Victoria Dispensary for Consumption and Diseases of the Chest, Edinburgh, in a communication upon the Etiology of Phthisis to the *British Med. Journal*, January 28, 1888, says, in conclusion: 1. In view of the work of Koch, it is impossible to avoid admitting that a causal relationship exists between the tubercle bacillus and the phthisical process. 2. The mere predication of this relationship is not sufficient in explanation of the clinical facts and the generally fatal termination of such cases. 3. The usually received explanations of the *modus moriendi* in phthisis are insufficient. 4. It appears probable that the lethal influence of the bacillus is due to the production thereby of certain poisonous products. 5. Clinical and experimental evidence appears to indicate that the morbid secretions from the respiratory surfaces afford a good medium for the growth of the tubercle bacillus, and, presumably, for the elaboration of such products. 6. Such a product is separable from the carefully selected and prepared sputum. 7. This product is possessed of well-marked physiological properties, being eminently toxic to frogs, mice, and other animals. 8. The toxic properties of the product are, generally speaking, depressant. 9. More particularly they include a marked depressant influence on the heart. 10. This depressant influence seems to be exerted through the medium of the cardio-inhibitory mechanism. 11. The toxic action of the product is more or less completely opposed by atropine. 12. The amount of the product which may be separated appears to bear a distinct relation to the abundance of the bacillar elements present. 13. Absorption of the poisonous product most probably occurs by way of the lymphatic circulation.

Black Tongue.

In the *Münchener med. Wochenschrift*, No. 14, 1887, Schech describes under the name "black tongue" a condition of the tongue which occurs without subjective symptoms and in which the coloration is not due to ingested coloring matter. The color is a more or less pronounced darkish or blackish brown, even blackish blue. Only at times is there a feeling of dryness, or a bad odor. The coloration begins for the most part immediately in front of the circumvallate papillæ, on one or both sides, and extends to the point of the tongue. The latter and the borders of the tongue are, in the meantime, nearly always normal. The affected parts seem rougher than the ordinary condition, and are set with longer or shorter fibres. This affection has been regarded as parasitic, and Dessois has given the name "glossophyton" to the fungus found in it. Schech, however, looks upon these fibres as excessively enlarged, pigmented and horny filiform papillæ. The cause has been referred to the smoking and chewing of tobacco, but probably this is a mistake. Treatment is unnecessary, as the affection causes no trouble. Weak alkaline mouth-washes are lauded; and, in case of necessity, mechanical removal of the fibres is recommended.

Ascending Paralysis after Whooping-Cough.

P. J. Moebius reports to the *Centralblatt für Nervenheilkunde*, 1887, No. 5, a case of paresis which developed in conjunction with whooping-cough. The patient was a child, three years old, and the paresis affected first the limbs, then the arms, the throat muscles and the diaphragm. Tendon reflexes were absent; but there was no disturbance in sensibility, no change of the electrical excitability, and no atrophy. After the paralysis had persisted several weeks, recovery occurred. The author believes that the disease is to be referred to an affection of the peripheral nerves—a multiple neuritis; he is inclined to regard it as a nervous sequela of whooping-cough, and as analogous to the post-diphtheritic paralyses.—*Centralblatt f. d. med. Wissensch.*, Dec. 10, 1887.

Sewage Farming in France.

The project to utilize the sewage of Paris in the lower part of the forest of St. Germain has been ratified by the French Chamber, notwithstanding the opposition of the residents of that district, who fail to see, in the more prolific growth of cabbages and other edible vegetables, an adequate compensation for the almost inevitable inconveniences of the system. Victor Hugo's remarks upon the wastefulness of the present system of sewage disposal in his well-known work, *Les Misérables*, will not have been merely interesting if they have aided in bringing public opinion around to his views. It was urged that over $5,000,000 was lost annually to agriculture by not consigning sewage to its natural destination—the soil—but all such estimates must be taken *cum grano salis*, seeing that in this country, where the system has been carried out on a very large scale, and on the most scientific principles, the authorities consider themselves very fortunate if they succeed in covering their expenses—a result indeed which is seldom attained. If the scheme prove satisfactory—and there is no reason why, with certain restrictions it should not be so—the present system of scavenging in Paris will be abolished.—*Medical Press and Circular*, February 15, 1888.

Terpin Hydrate.

In a communication on terebinthinates to the *Lancet*, March 10, 1888, Dr. Prosser James says that terpin hydrate has only a slight taste, is rather insoluble, has no odor, and is solid. It may be seen as small needles when it spontaneously crystallizes from a mixture of turpentine and water, or may be obtained in large rhombic crystals by allowing alcohol (three parts), turpentine (four), and nitric acid (one) to stand in shallow dishes three or four days. It is dissolved in only small proportion by cold water or turpentine, but is taken up more readily by hot water, alcohol and ether. For this reason it is best given in pills or wafer paper. For small doses pills containing two grains each are convenient, and one can be taken every three or four hours. For larger doses, which should not be repeated so frequently, wafer paper is better. An emulsion may also be made, but this is not an agreeable method. The hydrate may, however, be dissolved in warm glycerine, and after solution an equal quantity of some syrup may be added. It is well to begin first with small doses, as these are sufficient to act upon the bronchial mucous membrane and also to affect the kidneys. It will be found useful in restraining the cough and secretion of bronchitis, and in stimulating the membrane to more healthy action, perhaps also disinfecting the sputa. Germain Sée has also found that full doses restrain the copious sputa of some cases of phthisis, and he met with no gastric irritation after long continuance of the drug: but others have not been

equally fortunate. In some instances small doses seem to increase bronchial secretion. It has also been employed successfully in hæmoptysis.

Simple Ulcer of the Duodenum.

The practical conclusions of Dr. Bucquoy's recent publication upon a clinical study of simple ulcer of the duodenum, are thus stated in the *Gazette Médicale de Paris*, Jan. 28, 1888: Without doubt the disease has a latent character, which renders the diagnosis difficult, but it presents some symptoms which permit us to determine the existence of the duodenal lesion. Its symptoms are: 1. Intestinal hemorrhages or black vomit, beginning abruptly, occurring at times in the midst of apparent perfect health, without serious consequences, but, later, repeating themselves several days, with more or less intensity, in such a way as to compromise the life of the patients. 2. A pain, existing nearly always in the region corresponding to the inferior surface of the liver, a little to the right of the linea alba. 3. Some digestive troubles, or extremely violent attacks of colic, manifesting themselves ordinarily three or four hours after the ingestion of food. 4. Termination by perforation of the duodenum, followed by fatal peritonitis, or by repeated or alarming hemorrhages.

Rare Case of Acute Iodism.

In the *Wiener med. Presse*, No. 28, 1887, F. Heller reports the case of a man, 30 years old, who became salivated following a short course of treatment with mercury for a primary syphilitic sore. He was ordered:

℞ Potassii iodidi.....3j
Aquæ destillat.....f℥ij
Syrupi cinnamomi.....f℥iij
Mix. Sig.—Tablespoonful 3 times a day.

After the very first spoonful the patient felt a strong burning in the mouth, and soon great itching of the surface of the body, headache, violent pains in the fingers, benumbing of sensibility, feeling of dryness and irritation in the throat, and difficulty in swallowing. After a second tablespoonful of the medicine these symptoms were increased and there appeared on the palmar surfaces of both hands, and particularly of the fingers, small red, somewhat elevated maculæ, which were due to effusion of blood and were extremely painful. Then coryza, conjunctivitis, and flushing of the face also occurred. The pulse was about 100, the appetite not much affected. In spite of discontinuance of the drug the symptoms kept up for two days. The spots were then of a rusty-brown, painless and no longer elevated, and after eight days the iodism disappeared. The patient had some years before manifested a tendency to skin diseases, especially of a hemorrhagic kind.—*Centralblatt f. d. med. Wissensch.*, January 7, 1888.

Treatment of Puerperal Sepsis with Salicylate of Sodium and Alcoholics.

Von Jaksch, of Gratz, in a comprehensive article in the *Wiener med. Presse*, No. 1, 1888, speaks in the most positive terms of the value in puerperal sepsis of salicylate of soda in combination with alcoholics. His opinions are based upon fifty cases treated in the wards of Nothnagel, in Vienna, under von Jaksch's personal supervision. He began the administration of the drug by giving seven and a half grains of salicylate of sodium hourly until the temperature fell to normal, a result generally obtained in fifteen to twenty hours. Symptoms of intoxication were rarely observed; when they appeared in force the dose was reduced one-half. He considers symptoms of intoxication no reason for abandoning the treatment, and after four or five hours he was generally able to resume the original doses. In conjunction with this treatment he employs alcoholics in full doses, cognac, sherry, and any form of good wine being freely given, with the best possible diet. In the event of heart failure becoming imminent, hypodermic injections of camphorated oil and other cardiac stimulants were given. If five or six doses of seven and a half grains of the salicylate produce no effect, von Jaksch does not hesitate to give fifteen grains hourly, and considers the administration of four and a half to five drachms of sodium salicylate in twenty-four hours fully indicated in severe conditions. The only ill effect he has seen follow this treatment is mild delirium.

Von Jaksch is not prepared to assign to sodium salicylate a specific action upon puerperal sepsis, but he desires to call the attention of those who treat large numbers of puerperal women to its use, and he advises, in cases in which a moderate rise of temperature occurs *post-partum*, that the drug be given promptly, sixty to seventy-five grains daily, and if severer symptoms follow the full doses, he would administer the remedy, in doses of from forty-five to sixty grains daily, to pregnant women just before labor, when the surroundings are very unfavorable and non-hygienic.—*American Journal of the Medical Sciences*, March, 1888.

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STANDING OF THE PHYSICIAN IN THE COMMUNITY.

In a recent issue of *Truth*, MR. LABOUCHERE, its brilliant and somewhat opinionated editor, takes an English physician named Allan to task for having refused to attend a woman in confinement until he had been paid a guinea in advance for his services. During the delay incident to the woman's husband's securing the required guinea, his wife died. About the same time the *Medical Press and Circular* contained a letter from a physician, who complained because he was accused of having caused the death of a child with diphtheria, whom he attended, and upon whom he performed tracheotomy, actually sucking out the obstruction in the tracheotomy tube when it became clogged. He left his little patient doing well, with instructions to the parents to clear the tube in a like manner, if it became clogged again. These instructions were not carried out when the difficulty recurred, and the child died. In spite, however, of the physician's unwise zeal for this child's good, he did not escape being accused of having caused the very result he had done so much to avert.

In one of these stories we have an *ex parte* statement by a layman of what seems like heartless behavior on the part of a physician; in the other we have an *ex parte* statement by a physician of what seems like base ingratitude on the part of a layman. Both stories—whatever may be the merits of each case—indicate the unsatisfactory relations often existing between physicians and their patients in Great Britain: a condition which is frequently brought to the attention of the readers of English medical journals. In that country, it appears, medical men are continually struggling against distrust and suspicion, continually striving for an appreciation and recognition which is refused them or extended with apparent reluctance. Such occurrences as we have referred to above are supplemented by a sort of chronic lament from the medical journals that titles are not conferred upon physicians who distinguish themselves by scientific attainments or by the heroic performance of their duty, as they are conferred on men in other walks of life. And, on the other hand, it seems, at this distance, as if the ruling class in England looks upon medical men as belonging to an inferior class, whose effort to rise is too obstrusive and needs to be repressed.

This state of affairs is happily hard to understand in America, where no class in the community enjoys more the confidence and affection of the others. It may be because we have no distinctions which are not open to all who have merit and perseverence, that here the medical man occupies an enviable position in the social world, in the country as well as in the city. Whatever honors the community can bestow are freely bestowed upon physicians in America; and, better than this, the physician here enjoys to a very high degree the heart-felt love of those to whom he ministers. No men in America, we believe, have a more satisfactory lot than the doctors, surrounded by grateful and affectionate friends, and rewarded for their labors by substantial and sentimental returns which leave nothing to be desired. Here, as everywhere, medical men must work hard, and sometimes get no money for their best serv-

ices; but, in the main, they are the recipients of so much kindness that they are thoroughly happy and contented.

This very contentment, the sense of receiving all the appreciation which they deserve, is probably one of the most important reasons why they have so little occasion for discontent. There is no ground for pushing, and the community grants freely what it would, perhaps, never yield on compulsion. So it happens that in America the relations between medical men and their fellow-men are of the most satisfactory character. For this, let us all be duly thankful, and let us all endeavor to continue to enjoy it by continuing to deserve it. It will never cease, so long as medical men look more at what they do than at what they get, and labor—not for praise, but for praise-worthiness.

PRESCRIPTION OF COMMERCIAL FORMULÆ.

In another part of this number of the REPORTER we give space to a notice of an interesting pamphlet by Mr. Emlen Painter, a pharmacist of New York, in regard to the employment by physicians of certain compounds made and sold by manufacturing chemists. We have much sympathy with the desire of pharmacists to avoid the expense and pecuniary risk to which they are subjected by physicians who take up for a short time, and then abandon, the many preparations urged upon them by the agents of these enterprising firms. But the case is by no means so plain as Mr. Emlen supposes. Even the simple laxative pills which he cites as objectionable are, in our opinion, of great utility. He has greater confidence in the average druggist's assistant than we have, or he would not advise physicians in general to prefer extemporaneous preparations to those made in large quantity by firms which have acquired a reputation for integrity and skill in this work. It is not long since the writer of this editorial saw a qualified druggist's assistant measure out three times the ordered quantity of a drug and add it to a mixture nearly complete, which had to be thrown away when the error was detected. This occurrence indicates one of a number of reasons why the preparations of well-known manufacturers are often preferred by physicians to those which they can get made to order in the drug shops. In addition to this, the fact cannot be denied that many medical men are not loath to prescribe a manufactured article which gives them certain results, even though they do not fully understand what are all of its ingredients. To them it is something that they are saved the trouble of thinking out a formula, and they are by no means unwilling to take what they believe is the result of careful and skilful elaboration by others who have made a specialty of it, as a reliable remedy for the conditions for which it is recommended, and to continue to prescribe it as long as it produces the effects they desire.

In this we think they do well, and it rests with the pharmacists to convict them of error if they are wrong.

A more serious objection than that to which we have alluded is raised by Mr. Emlen against certain preparations, which he intimates are actually fraudulent, because they are not made up in accordance with their published formulæ. If this be the case, then they are undoubtedly frauds, and deserve the severest condemnation. But, we may suggest that the pharmacists, who have so great an interest in exposing the false pretensions of those whom they regard as their natural enemies, have an easy way of dealing with cases of this kind. Let a preparation which they suspect be purchased of the manufacturer and analyzed, and then let a suit be instituted against the manufacturer for obtaining money under false pretenses. It would not take many actions of this kind to free the market of preparations which are actually fraudulent. And, until something of this kind is done by those who are alone in the position to do it, pharmacists cannot justly blame physicians for prescribing remedies which accomplish for them what they desire, solely on the ground of unproved allegations.

We wish to say what is right in this matter, and, if we know it, will allow no un-

worthy considerations to influence our expressions of opinion; but we think there are two sides to the question, and we will gladly give space to a temperate discussion of it in our columns. What our readers want is to learn the truth, and we will not hide any of it from them, if pharmacists or manufacturing chemists will place us in a position to speak positively about this important subject.

TREPHINING FOR EPILEPSY.

The operation of trephining for the removal of a source of irritation of the brain which is suspected of being the cause of epileptic seizures is no longer a rare thing in surgical practice, and the indications for performing it are becoming better defined than they once were. At a meeting of the *Société Médicale des Hôpitaux*, February 24, 1888, M. Ferré presented a patient, thirty-six years old, upon whom such an operation had been successfully performed. The man had been wounded on the vertex by a fragment from a bursting shell, and six months later had begun to suffer with attacks of epilepsy occurring about twice every month. There was a small area of hyperæsthesia at one end of the cicatrix, irritation of which brought on epileptic crises. M. Ferré thought that there was no absolute lesion of the cortex, because the convulsions were not limited to any single part, but affected all four of the limbs synchronously. He therefore called upon M. Reclus, a surgeon, to operate upon the patient. M. Reclus performed the operation of trephining, November 29, 1887, and found a slight depression of the internal table of the skull at the posterior part of the cicatrix. Since the operation the patient had had no return of his epileptic attacks.

The issue of this case is encouraging, although it is too soon to say that a cure has been effected. Similar results have been obtained in other cases in which the attacks afterwards recurred. But this fact does not discredit the operation; for it is no small matter to free a patient for a reasonable time from the horrors and dangers of epilepsy, and it is always possible that an actual cure may be effected.

CELEBRATION IN HONOR OF PROFESSOR AGNEW

On the evening of April 6, 1888, a dinner was given to Prof. D. Hayes Agnew, of the University of Pennsylvania, to celebrate the fiftieth anniversary of his graduation in medicine. The banquet was attended by about two hundred and fifty friends and admirers of Dr. Agnew, and was a very brilliant affair. The usual complimentary speeches were made by gentlemen selected to respond to the toasts, and two poetical contributions added variety to the proceedings. In so far the affair differed in nothing from what happens whenever a man of distinction receives a testimonial of this sort. But there was a feature of the occasion which deserves special mention. This was the peculiar atmosphere of affectionate regard for the guest of the evening, which pervaded the magnificent hall in which the dinner was enjoyed, and the feeling that he in whose honor it was given is so sincerely loved, as well as respected, by an unusually large number of his professional brethren. The reason for this may be stated —not so much in praise of its object as for an incentive to others. Skill and perseverence have won for Professor Agnew the admiration of all who know his ability as a surgeon; unblemished integrity has secured for him the respect of all who know his character; but it is his pure unselfishness and uniform kindness to all with whom he comes in contact which has made him the object of a warm affection, which must be dearer to him than any other reward which he has received for his years of faithful labor. Few men have enjoyed such honors as he has enjoyed without exciting the envy of those who never secured them. But for him they come beautified by the assurance that those who may not share them, love him not less, but more, because of them, and see in each new tribute to his attainments and virtues only an occasion for new enjoyment and warmer regard.

Such a life does good, not only by what it accomplishes, but also by what it teaches; and the occasion which calls attention to the principles of such a hero will serve its best purpose if it leads those who admire, to emulate his example.

CARE OF THE PAUPER INSANE.

There is at the present time a Committee of the Senate of the State of New York engaged in taking testimony in regard to the need for and advisability of a proposed law taking from the counties of that State the right and duty of caring for their own pauper insane and handing them over to the State establishments. From the evidence which has been published, and especially from that given by members of the New York Charities' Aid Society, it appears that there can be little doubt that the pauper insane are not so well cared for under the jurisdiction of county authorities, as they are in establishments under the management of the State. This is in accord with experience elsewhere, and is not different from what one would expect who understands human nature, and who knows the conditions under which institutions of this kind are apt to be managed in this country. It is to be regretted that too many such establishments are managed wholly in the interest of politicians, and that the inmates of them are often mere excuses for handling money to those who have charge of them. Happily this condition of affairs is every day more and more giving place to humane and honest methods, which are everywhere sure of the support of intelligent medical men. We call attention to the matter now, because it is possible that among our readers in the State of New York there are those who may very much assist the cause of humanity and of science by lending their aid to those who are, at this very time, trying to rescue the pauper insane of that State from the remorseless grip of the politician. Now is the time to help, and our readers may be able to determine which way the balance of the legislative mind will turn on this serious question.

—Dr. William B. Dewees, of Salina, Kansas, received, on March 19, the gift of a fruit knife which had belonged to his famous ancestor, Prof. Dewees, of the University of Pennsylvania. The knife is made of silver and pearl, and bears the crest and legend of the family of its former owner.

Book Reviews.

[Any book reviewed in these columns may be obtained, upon receipt of price, from the office of the Reporter.]

THE YEAR-BOOK OF TREATMENT FOR 1887. 8vo, pp. 336. Philadelphia: Lea Brothers & Co., 1888. Price, $1.25.

This is one of the most valuable books for its price which is published in this or any country. It contains a summary of the changes in medical practice, the new remedies introduced, and the experience with them and with others which have been longer in use, during the year 1887, made up from the reading and observation of a number of very capable men in England. The classification is according to diseases, so that one who consults these pages can obtain in a few minutes an excellent idea of the present status of therapeutics in regard to any given ailment. The book also has a good index, by means of which the reader may ascertain the different diseases for which any particular drug has been used during the year last past. We can recommend it highly to our readers, feeling sure that it will prove helpful to them in their practice.

ELEVENTH REPORT OF THE STATE BOARD OF HEALTH OF WISCONSIN, 1887. 8vo, pp. 236. Madison, Wisconsin: Democratic Printing Company, State Printers, 1888.

This report contains much interesting reading of the sort common to most publications of like character; but in addition we find in it a number of essays which deserve special notice. Among them, we may mention an exceedingly intelligent review of the subject of bacteria in their relation to natural and pathological processes by Professor E. A. Birge, of the State University, and a timely supplement to it, under the head of "Recent Progress in Preventive Medicine," by Dr. J. L. Kaine, of Milwaukee. In a paper on "The Physical Side of Education," Professor Anderson, Superintendent of Schools in Milwaukee, properly and severely characterizes the tendency to push children too hard in their studies and to overlook the necessity for play—not gymnastics, but actual play. The paper of Dr. B. O. Reynolds, of Lake Geneva, on "Ideal Sanitation," contains a number of truths which would be of great service, if they could be properly impressed upon the minds of the community.

Before leaving this interesting volume, we must commend the effort of the Board to prevent the appointment of unfit persons to the position of local health officers, and express the hope that their suggestions will not lose their effect because they are couched in such temperate language. To our readers, especially those in Wisconsin, we may add that they would do well to get a copy of this report, if possible, and catch from it a spirit of intelligent sympathy with their own State Board of Health, for their own good and for the good of their State.

TRANSACTIONS OF THE CONNECTICUT ECLECTIC MEDICAL ASSOCIATION FOR THE YEARS 1886–7. Vol. I. 8vo, pp. 130. Bridgeport, Conn., 1887.

This volume contains an interesting account of the rise and progress of the organization whose name it bears. Its scientific papers contain much that is creditable to the good sense and power of observation of those who contribute them. If our readers could go over them carefully, we think they

would regret that men who exhibit so much intelligence should persist in contending as vigorously as they do for a name, and fail to see that no school of medicine is so thoroughly eclectic—in the best sense of the word—as that from which they voluntarily exclude themselves. The distinction between those who *call themselves* "eclectics" and those who abjure an exclusive name is one which is to be regretted, because it severs those who ought to be brethren; and it is to be hoped that the time will yet come when those who merely trade upon special designations will be left wholly to themselves, and the honest men who now follow in error their banner will see that they belong with the great army of healers, who have no motto except that which Dr. Oliver Wendell Holmes has so beautifully expressed for them.

TRANSACTIONS OF THE MEDICAL SOCIETY OF THE STATE OF WEST VIRGINIA. Twentieth Annual Session, 1887. 8vo, pp. 155.

The West Virginia Medical Society has not yet reached the age of some of its sisters; but it is a vigorous and active member of the family, and can already look down upon a number of juniors. The volume of transactions before us bears the marks of keeping up with the progress of medical science in other parts of the world. It is not easy always to select papers for special mention from such a collection; but we may perhaps designate those on "Hypnotics," by Dr. C. C. Hershman, of the West Virginia Hospital for the Insane, and that of Dr. W. W. Tompkins, of Charleston, on "New Remedies in Surgery," and a short paper on "Non-closure of the Abdomen," by Dr. Wm. Hogue, of Charleston, describing two interesting cases of this defect, and illustrated by a wood-cut. The other contents of this volume are both interesting and instructive, and lead to the regret—so often felt in going through the Transactions of State Medical Societies—that so many of the papers read before these bodies do not get a wider circulation.

Pamphlet Notices.

[Any Reader of the Reporter who desires a copy of a pamphlet noticed in these columns will doubtless secure it by addressing the author with a request *stating where the notice was seen* and enclosing a postage stamp.]

THE MEDICINES OF MEDICINE. Reprint of a paper read at the 35th Annual Meeting of the American Pharmaceutical Association. By EMLEN PAINTER, Ph.G., New York, September, 1887. 8 pages.

—Mr. Painter's paper contains a warm plea against the prescription by physicians of special makes of pills and potions, some of which, he claims, are in no way preferable to what any capable pharmacist can compound, and some of which are not at all what they are said by their makers to be.

A VERY VALUABLE LESSON FOR THOSE WHO USE ANÆSTHETICS. By JULIAN J. CHISOLM, M.D., Baltimore. Read before the Baltimore Academy of Medicine, December 6, 1887. 15 pages.

—Dr. Chisolm is one of few surgeons in the United States who habitually uses chloroform as an anæsthetic. He computes his administrations of it at about ten thousand cases. He uses it almost daily, and has never lost a patient from its effects. This remarkable experience adds greater interest to the very interesting story he tells in the pamphlet before us of the narrow escape from death by chloroform narcosis of a little patient on whom he recently performed enucleation of the eyeball. His story serves as an introduction for a strong recommendation of chloroform as an anæsthetic, and a convincing presentation of the way in which it should be administered, as well as of the measures to be adopted in case of threatened death from its effects. This may be expressed in a single sentence: suspension with the head down. We recommend Dr. Chisolm's pamphlet very strongly to the attention of our readers.

Literary Notes and Queries.

[In this column the Reporter will publish short items of literary interest and questions addressed to this Journal or its readers, and answers to them, in regard to any literary matters: books, authors, places and prices of publications, etc.]

—In consequence of the confiscation of three articles by the official Censor, the appearance of the February number of the *Medizinskoïe Obosrenïe*, a leading Russian medical review, has been delayed a month.

—Dr. Benjamin Ward Richardson has written a novel entitled "The Story of a Star; a Romance of the Second Century." The hero is Bar Cohab, the last of the great leaders of the Jewish people in the final struggle for national independence. It is shortly to be published in the orthodox three-volume form by Messrs. Longman & Co.

Correspondence.

Early Accounts of Diphtheria in New England.

EDITOR MED. AND SURG. REPORTER:

Sir:—A medical work printed in London in 1758 came into my possession from the library of an old doctor, entitled *Medical Observations and Inquiries, Vol. I.*, which gives an account of "the first appearance of the throat-distemper at Kingston, an inland town of New England, about the year 1735." This article was an extract of a letter from Cadwallader Colden, Esq., to Dr. Fothergill. The facts were obtained chiefly from correspondence with Dr. Douglass, of Boston.

Kingston being an inland town it was concluded that the disease could not have been imported. It moved slowly westward and did not reach the Hudson river, where Dr. Holden was then stationed, for about two years. And it seemed to attack those towns through which New England people travelled. It continued to travel westward until all the British colonies were attacked. At that time it was considered contagious, although isolated families were affected in the tract of the epidemic. For fourteen years after its

first appearance it continued to break out afresh here and there.

The writer says: "The seeds of this distemper seem to be hatching in the humors of the body, before any particular symptoms of it appear. A corrosive humor bred in their issues, or in other sores, when they had any, and any constitutional ails were sometimes revived." Speaking of the furring on the tonsils, he says: "the tough cream colored sloughs were thrown off. The tonsils appear deeply pitted and corroded, and the sloughs are soon again renewed. Sometimes all the parts near the gullet or throat are much swelled, both inwardly and outwardly, so as to endanger a suffocation, and frequently mortify. Sometimes these swellings imposthumate."

Many of the cases were up and walking about until a very short time before death. And some died before any one suspected any danger. The fatality was great. Some cases were treated with bleeding, and with purgatives. "All sensible evacuations of every kind, after the disease has continued some time, are destructive. The consequences of of them are, a general tendency in the humors of the body to unsurmountable mortifications; so far, that the orifice made by the lancet in bleeding, and the adjacent parts, mortify. So likewise the places where blisters were applied, mortify; and the *ichor*, which issues from them corrodes all the parts on which it distils, and produces mortifications."

Dr. Douglas, of Boston, was given the credit of discovering the first successful method of cure. His treatment consisted in keeping the patient warm in bed, keeping up a free perspiration by warm drinks: sage tea mostly. Serpentaria was used as a diaphoretic. He "found well dulcified mercury of use, especially when joined with camphire." Gargles of a decoction of sumach berries, serpentaria, and alum were used. The compound tincture of aloes mixed with honey was used on the tonsils. Fomentations of bitter herbs, *sal armoniæ*, borax, salt, and vinegar, were used on the throat when swollen.

This article contains many other quaint views on the pathology of this throat disease, as well as on physiology and treatment which will not be quoted here. Already I have drawn sufficiently on the original text to show the prevalence of diphtheria at that early date. Undoubtedly it prevailed before that time, but this writer was unable to bring forward the facts. He recorded it as it appeared at that time.

It also appears that he regarded it as a peculiar form of disease, differing from any that he had seen or read of in England.

Newport, Vt. JOHN M. CURRIER.
March 8, 1888.

Difficult Twin Labor.

EDITOR MED. AND SURG. REPORTER:

Sir:—On Sept. 26, 1887, I was called to see Mrs. Y., about 36 years of age. On my arrival I found her in the first stage of labor. On examination per vaginam I found a breech presentation. The os uteri being well dilated, and seeing nothing unusual in the case, I thought best to let nature do the work. Labor progressed finely until the child was expelled to the shoulders, and one shoulder and arm were expelled. At this stage it seemed to refuse to be moved by the expulsive efforts of the uterus. I then brought down the other arm, and the child was born to the neck. But still it refused to move any further. I introduced my finger up by the side of the neck to try and find out the trouble, when it came in contact with another head, which was presenting lower down than the first, and this was a vertex presentation. Finding out the condition of the case, I was at a loss to decide what would be best to do. However, as the woman was stout, and the expulsive efforts good, I did not have to wait long before the second head came down by the neck of the first child, and the second child was soon born. The next pain brought the head of the one that was born to the neck. Though it had died from pressure on the cord, I tried the prescribed means of resuscitation, but failed. They were carried to full term, weighing seven and one-half pounds each. The mother was not injured in any way and made a good recovery. As this was an unusual case with me, I thought I would report it in a very short manner. Is there any way to diagnosticate such a trouble, and adjust it before the first child's body is born? All that I could do in my case was to place the child in the best position for the other to pass. Would like to hear from the editor and readers of the MED. AND SURG. REPORTER in regard to it.

W. H. BARNES, M.D.
Homewood, Miss., March 23, 1888.

About Advertisements.

EDITOR MED. AND SURG. REPORTER:

Sir:—Your editorial on "Reading Notices," in the MEDICAL AND SURGICAL REPORTER, March 17, p. 347, should receive the hearty approval and commendation of

every reader, and your periodical the substantial support of every just-minded medical man. Advertisements should be confined to the advertising columns. The insertion of "reading notices" and advertisements among the reading columns and pages is detestable and should be deemed good and sufficient reason for casting into the fire any periodical in which this is practiced. True, these notices pay large sums; and it is refreshing to see some secular periodicals rejecting such dishonorable service of Mammon. How humiliating, on the other hand, to note so many religious papers and magazines for greed of lucre, holding up to public gaze disgusting, and even filthy things? Here is one that, under the head (in capitals) "Religious Notices," inserts four lines in the way of religious matter, and then follow a number of short and longer notices of shams and frauds and charlatanisms to draw forth money for those whose "ads" are not allowed in pure secular papers.

D. L. Phares.

Agricultural and Mechanical College, of Mississippi.

March 21, 1888.

Notes and Comments.

Treatment of Epidemic Dysentery.

Dr. J. W. McLaughlin, of Austin, Texas, says: "The following list of medicines comprises those upon which I usually rely to meet the various indications which come up in this form of dysentery: Opium, quinine, turpentine, camphor, naphthaline, mercuric salts, chlorine water, nitrate of silver, sulphurous acid, tannate of bismuth, kino and ergot; concentrated food, meat preparations, milk and brandy. In those grave forms of dysentery characterized by profound toxæmic depression and threatened death from heart failure, I confidently recommend turpentine in large doses. It is an excellent hemostatic, a good antiseptic and a valuable stimulant, well suited from its prompt action to arrest the destructive tendency of this fearful malady, and counteract threatened heart failure." If the pulse is rapid and weak, the patient restless and sleepless, he gives morphia and chloral hydrate to secure rest and sleep; if the pulse is slow and sluggish, the patient inclined to stupor, small doses of atropine for its action upon the terminal ends and ganglia of the vagus. Brandy, digitalis and strychnia are indicated, he says, as cardiac stimulants and conservators, and ergot and kino to control intestinal hemorrhage. Quinine, mineral acids, carbo ligni, resorcin and other antiseptics and astringents, will be found useful in the varying phases of dysentery. He also recommends injections of large quantities of water to which should be added antiseptics and astringents, *e. g.*, boric acid, borax and salicylic acid, tannic acid, nitrate of silver, alum, or chlorine water. In the ordinary run of cases, those in which the system is less profoundly impressed and which pursue a slower pace, naphthalin is recommended and in his hands has given excellent results. The mercuric salts and chlorine water are recommended in the diphtheritic forms, sulphurous acid and tannate of bismuth, in the typhoid forms, and simaruba, columba, nux vomica and cinchona in the convalescent stages. Rest in bed, cleanliness of person and clothing with proper feeding are absolutely essential to the success of any plan of treatment. He objects to the practice of stuffing patients, forcing upon them food when they neither desire it nor can digest it, as he feels sure such practice is harmful to the patient. If the patient desires food and his stomach can digest it, by all means, he says, let him have it, but when the contrary condition is present it is better to withhold food, or select that which is least objectionable to him: sweet milk, peptonised or with lime water; frozen cream if it is grateful, meat juice and meat broths, are to be recommended. The same rules should govern in giving whisky or brandy in dysentery, which are observed in its administration in other diseases.

Food and Food Adulterants.

An article in *Science*, March 23, 1888, calls attention to a recent report of the United States Department of Agriculture on foods and food adulterants, which treats of fermented alcoholic beverages, malt liquors, wine and cider, and represents a vast amount of work by C. A. Crampton, the chemist, and his assistants. The opening sentences of this report are calculated to excite a good deal of thought and reflection. The production of malt liquors in this country is second only in importance as an industry to the production of breadstuffs. Their consumption is steadily on the increase, as is also the amount consumed in proportion to other kinds of alcoholic beverages. In 1840 23,310,843 gallons of malt liquors were consumed in the United States. In 1886 the amount reached 642,967,720 gallons. In 1840 the consumption *per capita* was 1.36 gallons, while in 1886 it was 11.18 gallons. During the same period the consumption

per capita of distilled spirits has decreased from 2.52 to 1.24. It is estimated that the amount expended for beer per annum is $304,852,683, placing the cost to the consumer at 50 cents a gallon. The annual cost to the consumer, of all liquors consumed, is placed at $700,000,000. In speaking of the enormous consumption of beer in the United States, Mr. Crampton, who prepared the report, says that no beverage compares with it, in the amount consumed, except water, and possibly milk; and that but little supervision has been exercised over its manufacture and sale, except the rigorous enforcement by the government of its demands for a share in the profits. The average amount of alcohol, by weight, in American beers is 4.63 per cent. Of thirty-two samples analyzed by the department, salicylic acid was found in seven. These were all bottled beers, one of them being imported. None was found in any of the draught beers. Of the nineteen samples of American bottled beers analyzed, six contained this acid. These six included the product of some of the largest breweries in the country—beers that are used to a very large extent all over the United States. Whether the acid is added in the breweries where the beer is made, or by the local bottlers, could not be determined. The acid is added to prevent fermentation, and, as has been shown by Dr. Bartley, formerly chief chemist to the Brooklyn Board of Health, the amount which beers contain is sufficient to be injurious to health. Of seventy samples of wine examined by Mr. Crampton, including champagne, burgundy, claret, sherry, sauterne, and other wines in common use, eighteen contained salicylic acid, and thirteen sulphurous acid, which had been added as such or in the form of a sulphite. One sample in forty contained one aniline dye-stuff, probably fuchsine; this was a California claret. In the analyses which were made of cider, some were found to contain as much as 8.09 per cent of alcohol by weight, the average being 5.17 per cent. These were all well-fermented ciders, and all bottled but one. In the 'sweet' or incompletely fermented ciders, the percentage of alcohol averaged 1.40, the lowest being 0.20, and the highest 3.46. No salicylic acid was detected in any of the ciders examined, and but one was adulterated. This was a bottled "sparkling cider," handsomely put up in neatly capped bottles, and of a clear, bright color. In it were found both bicarbonate of soda and a sulphite. This report is in its entirety a most valuable one, replete with information which is interesting to the general reader, as well as instructive to the scientist.

The Female Doctors.

Several years ago three Russian female doctors established a hospital and dispensary for Mohammedan women at Tashkend, the capitol of the now Russian province of Sir Darya. The idea was a happy one, and it has been attended with the best results, for an institution of the kind filled a long-felt want. Patients attended daily, who otherwise would have had to go without medical assistance, as doctors are not admitted in Mohammedan homes. Last year the three lady doctors gave no less than 15,000 consultations at their establishment.

A Drug Clerk's Fatal Mistake.

The *National Druggist*, Feb. 15, 1888, states that a prescription clerk in St. Louis made a mistake in the substitution of compound syrup of ipecacuanha (Dover's syrup, or syrup of Dover's powders) for syrup of licorice. The child for whom the prescription was ordered, died after taking a few doses of the medicine, and the clerk was immediately arrested and locked up. This is only one more instance emphasizing the necessity of including dover's powder and the syrup thereof among the poisons, and keeping them in the poison case.

Formula for Syrup of Yerba Santa.

E. Y. Johnson, in a communication to the *Druggist's Circular*, April, 1888, says that the following syrup will effectually disguise the taste of forty or more grains of sulphate of quinine to the fluid ounce. He says he has questioned several physicians who have used a great deal of it, and all say it gives perfect satisfaction. The following is the formula:

Fl. ext. yerba santa	1 fl. oz.
Carb. magnesia	6 drs.
Refined sugar	4 fl. oz.
Water	4 oz.
Oil of pimenta	10 drops.
Oil of cloves,	
Oil of cinnamon, of each	6 drops.

Rub the magnesia and sugar together until thoroughly mixed, then drop in the oils and the fluid extract of yerba santa, and rub until nearly dry. To this add the water, mixing well, and lastly, add a mixture of glycerin 4 ozs., water 5 ozs., rub well, pour on a filter and add water to make the filtrate measure 15 fl. ozs. In this dissolve by agitation refined sugar 14 ozs. (av.), and add to the

whole mixture citrate of potassium 75 grs. previously dissolved in a little water and let stand two hours. Filter through a wetted filter, returning until it passes clear. The above, he says, gives a perfectly clear, brilliant syrup which will not cloud by standing.

Horrible Murder by a Monomaniac.

A very singular occurrence, says the *British Med. Journal*, February 11, 1888, has recently taken place at Gortley, a village not far distant from the famous Gap of Dunloe. On Saturday, February 4, six members of one family, in a fit of madness, murdered an idiotic boy, 13 years old, and threw his body into the yard adjoining the house. The perpetrators of the deed are now inmates of Killarney Lunatic Asylum, but the mother of the lad confessed to have had some hallucination that so long as he lived the family would be subject to evil influences. On this account she acknowledged having killed her son with a hatchet.

Toothache Pellets.

The *Chemist and Druggist*, March 17, 1888, suggests the following:

Cocaine hydrochlorate	grs. 16
Powdered opium	grs. 64
Menthol	grs. 16
Powdered althæa	grs. 48
Mucilage of acacia	grs. 9

Make into ½-grain pills and keep in well-stoppered vials. For use, one of these is to be inserted into the hollow tooth.

State Medical Society of Arkansas.

The next meeting of the State Medical Society of Arkansas will be held at Fort Smith, April 25, 26 and 27, 1888. It promises to be one of the most largely attended meetings since the Society was organized. A large number of interesting papers have been promised, most of them of a highly practical character.

The sessions of the Society will be held in the hall of the Young Men's Christian Association, beginning on Wednesday morning. Reduced rates of fare will be granted to those members of the Society who purchase not more than five days before April 25, full fare tickets to Fort Smith, taking a certificate from the ticket agent, which will be endorsed by the Secretary of the Society, and secure return tickets at one cent a mile. Return tickets must be purchased on or before April 28.

The Secretary of the Society is Dr. L. P. Gibson.

NEWS.

—Sir Andrew Clark has been elected President of the Royal College of Physicians of England, succeeding Sir William Jenner.

—Dr. John M. Browne has been appointed by President Cleveland Surgeon-General, to succeed Dr. F. M. Gunnell, whose term expired March 26.

—Professor Hattie Allen, who has just assumed an important chair in the Medical Department of the University of Michigan, is said to be only thirty years old, and is a Vassar alumna.

—The California State Medical Society will hold its annual meeting, April 18, in San Francisco. Dr. C. G. Kenyon, 664 Mission St., San Francisco, is chairman of the Committee of Arrangements.

—It has been proposed that a statue or a monument be erected to perpetuate the memory of the late Henry Bergh, the world-famous friend of the dumb animals, and consequently the friend also of humanity.

—S. Moriyasu, from a study of a large number of Japanese girls with reference to the age at which menstruation began, concludes that the first appearance is on an average between the ages of fifteen and sixteen years.

—The *Kansas City Medical Index*, March, 1888, says that one of the brightest and most promising young physicians of that city, has been forced to give up his practice—in fact, has become a perfect physical wreck—from the use of cocaine.

—Dr. Nicholas Senn has been appointed Professor of the Principles of Surgery and Surgical Pathology in the Rush Medical College, Chicago; and Dr. Frank T. Andrews Professor of Practical Medicine in the Chicago Medical College.

—The death of Dr. Leopold von Holst, who was for a long time one of the editors of the *St. Petersburger med. Wochenschrift*, is announced. He had been a sufferer for many years from chronic bronchitis and emphysema, but his death was occasioned by pyæmia. He died March 6.

—The degree of Doctor of Medicine was conferred upon 188 graduates of the Jefferson Medical College at the sixty-third annual commencement, April 4. Professor J. W. Holland, Dean of the Faculty, awarded the prizes, and Professor Roberts Bartholow delivered the valedictory address to the graduates.

HUMOR.

"EVERYTHING I HEAR goes in one ear and out of the other," said a dude to Charley St. Clair yesterday. "Why shouldn't it?" said Mr. St. Clair, "for there's nothing to stop it."—*Boston Beacon.*

"FATHER," SAID THE EDITOR'S LITTLE BOY, "is the new Emperor of Germany an editor? I see when he speaks of himself he says 'we.'" "No, my son. That is a word the emperors have stolen from the editors without proper credit."—*Peoria Transcript.*

EXCITED WIFE—O John! John!. Quick! Stop fumbling behind that bureau and run for a doctor. Half-dressed husband—What's the matter with you, anyhow? "Baby has swallowed your collar-button." "How on earth do you expect me to get ready to go for a doctor without that collar-button?"—*Omaha World.*

"YOU OUGHT TO BE ASHAMED OF YOURSELF, a great big man like you to be a beggar and a tramp! You oughtn't to be afraid of work." "I know it, mum, but I can't help it. You see my nurse frightened me once in a dark room when I was a baby, and I have been timid ever since."—*N. Y. Mail and Express.*

OBITUARIES.

BENJAMIN F. DAWSON, M.D.

Dr. Dawson died in New York at the age of 43 years. He served as Acting Assistant Surgeon in the United States Army during the last year of the rebellion. After graduation at the College of Physicians and Surgeons in 1886 he paid special attention to obstetrics and the diseases of women and children. In 1868 he founded and until 1874 edited the *American Journal of Obstetrics*, and to that and other similar publications was a constant contributor. In 1876 he invented and published an account of a new galvanic battery for galvano-caustery surgery, which attracted much attention. He was a member of numerous societies, medical and scientific.

JOSEPH A. PAXSON, M.D.

Dr. Joseph A. Paxson died at his residence in Philadelphia, April 5, after a short illness. Dr. Paxson was born in Bucks county, in 1842. He came to this city in 1863 and became a teacher in the Friends' School at Fifteenth and Race streets. He was graduated from the Medical Department of the University of Pennsylvania in 1869. After practicing medicine in Buckingham, he came to Philadelphia in 1875. He held at different times several positions of trust, and took considerable interest in political matters. His wife and two children survive him.

WILLIAM C. SPENCER, M.D.

Dr. William C. Spencer, died of pneumonia at Fort Trumbull, Conn., March 22, after an illness lasting two days. He was appointed Assistant Surgeon in 1861, promoted to Captain and Assistant Surgeon in 1866, and to Major and Surgeon in July of the same year. He was breveted Lieutenant-Colonel March 13, 1865, for faithful and meritorious service during the war. He was fifty years of age.

WILLIAM B. SMALL, M.D.

William B. Small died in Philadelphia, March 31, at the age of about 75 years. He was born in Philadelphia, and was graduated from the University of Pennsylvania in 1833. From that period until within a short time of his death he was in active practice. In his earlier years he gained a reputation for his services in various epidemics of small-pox and yellow fever, and was physician to one of the pest houses, at that time located at Bush Hill. He was at one time a member of the City Gas Trust and was Chairman of the Committee on Distribution.

THOMAS F. TEBBS, M.D.

Dr. Thomas F. Tebbs, of Prince William county, Va., died in Haymarket, Va., January 27, 1888, after a short illness. He was graduated from the University of Pennsylvania in 1849.

Official list of changes in the Stations and Duties of Officers serving in the Medical Department, U. S. Army, from April 1, 1888, to April 7, 1888:

Col. Jedediah H. Baxter, Chief Medical Purveyor, Maj. Chas. R. Greenleaf, Surgeon, detailed as members of an Army Retiring Board, appointed to meet at Washington, D. C., on Wednesday April 4, 1888. S. O. 75, A. G. O., April 2, 1888.

Maj. Chas. H. Alden, Surgeon, will repair to Washington, D. C., on public business, and on the completion thereof will return to his station (West Point, N. Y.) S. O. 75, A. G. O., April 2, 1888.

Capt. Victor Biart, Asst. Surgeon, having been found incapacitated for active service by an Army Retiring Board, sick leave of absence is still further extended until further orders on account of disability. S. O. 77, A. G. O., April 4, 1888.

Capt. Edwin F. Gardner, Asst. Surgeon, leave of absence extended fourteen days. S. O. 77, A. G. O., April 4, 1888.

Official list of changes of Stations and Duties of Medical Officers of the U. S. Marine Hospital Service, for the four weeks ended April 7, 1888:

S. T. Armstrong, Passed Assistant Surgeon, granted leave of absence for fourteen days. March 21, 1888.

W. D. Bratton, Passed Assistant Surgeon, promoted and appointed Passed Assistant Surgeon, from April 6, 1888, April 2, 1888.

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Communications.

OPERATION UPON A LACERATION OF THE CERVIX AND PERINEUM: PERITONITIS, ABDOMINAL SECTION, DEATH.

BY HOWARD A. KELLY, M.D.,
PHILADELPHIA.

It is a saying as true as it is trite, that a careful study and a proper appreciation of the causes of our failures, frequently teach us more than many successes. And to this end, with a desire to extract as much good as possible from a very sad case, which has recently occurred in my surgical practice, I present the following report:

Mrs. B. came to me from a distance, sent by her family practitioner, a man of high skill and reputation, living in the northern part of the State. I found upon examination, that she had a very unusual form of laceration of the cervix, extending obliquely from the left, anteriorly, to the right, posteriorly, completely dividing the cervix into the vault of the vagina, leaving two puffy infiltrated lips. From its anterior left extremity, the tear had extended far into the vault and leaving as its sequel a well-defined, broad, sharp-edged band of scar tissue. The vaginal outlet was slightly torn, and greatly relaxed. A careful bimanual examination showed that the pelvic connective tissue also carried the scars of old inflammation, but there were at present no foci of any active, or sub-acute inflammation, nor were there any cystic deposits or pus pockets discoverable within the pelvis. The injury was one of which I have seen many examples, resulting apparently, in the light also of the well detailed history, given me by her physician, from a very difficult forceps labor, occasioning great damage to the maternal soft parts, and followed by a severe attack of puerperal fever, confining her several months in bed. She was etherized for operation on the 9th of March. Both cervix and perineum were repaired at the same sitting, lasting about forty minutes; and I followed the same steps satisfactorily employed in several hundreds of cases previously. She took the ether very badly, resisting violently when inhaling it, and retching for a long time as she was coming out of its influence. In brief the operation was conducted as follows: The cervix was well exposed by Simon specula, and held by a tenaculum, exercising very little traction, on account of the condition of the vaginal vault and connective tissue above mentioned. The lips of the tear were quickly denuded with scissors, and brought together by three sutures of silk-worm-gut on one side, and two on the other, which were held by clamped shot. No sponges were used throughout. Cleanliness and comfort were insured by continuous irrigation, pouring a steady stream of carbolized water on the field of operation. The relaxed vaginal outlet was quickly repaired by means of the Emmet operation, and closed with shotted silk-worm-gut sutures. For thirty-six hours the patient's condition was comfortable, and there was nothing to excite especial attention, until on the third day I noticed a quickening of the pulse, for which she was given tincture of digitalis, which was stopped on the day following on account of vomiting. Her pulse on the fourth day was 124, and she was vomiting frequently, and complaining of pain across the lower part of the abdomen. Throughout this day and the day following, in spite of the most careful attention, close watching and judicious medication and feeding, the pulse continued from 120 to 130, and the temperature ranged from 100° to 102°. The next day

at midnight the matron of my hospital called me, with the report that the pulse had gone up to 140. I ordered her to prepare at once for an abdominal section, with thorough irrigation of the peritoneum. My associate, Dr. Robb, who was dressing to go with me, asked me if it would be well first to take out the stitches in the vagina and cervix? I replied that I was certain that some as yet mysterious cause had given rise to an attack of *peritonitis* instead of cellulitis, and I felt equally confident that the field of operation was not directly to blame. Several possibilities lay before me—either in some unaccountable way, unprecedented in my experience, the field of operation had become infected, and transmitted the poison to the peritoneum; or else some lingering trace of the old pelvic inflammation, in the shape of a small pus cyst had been ruptured by manipulation during the operation or vomiting, and the peritoneum had thus directly been infected. My confidence in the conditions which surrounded the field of operation was such that I unhesitatingly acted at once upon the latter supposition, which was supported by a careful digital examination per vaginam, showing that there was no deposit in either broad ligament. Under the influence of chloroform, with the assistance of Dr. Hunter Robb, I quickly opened the peritoneum, and was at once rewarded by finding about two ounces of grumous pus lying free in the pelvis among the intestines. I washed the cavity out well, and closed the incision down to a drainage-tube, in the lower angle, resting in the pelvis. A curious fact attracted my close attention when making the incision; after cutting through the skin and fasciæ, I opened a small duct-like structure, plicate, and looking like bladder tissue. I feared for a moment that this was an unobliterated urachus. But as no discharge came from it, I continued opening the peritoneum. She informed me on the following day, that she had for some years had an intermittent purulent discharge from the navel, which in the interim appeared clean and healthy. This discharge ceased from this time, and I could discover no trace of it subsequently. The first object of my care upon opening the peritoneum, and finding the puriform grumous accumulation, was to discover the condition of the pelvic organs. I slipped my fingers behind the uterus, and found that ovaries, tubes, broad ligaments, uterus and cervix were normal. No adhesions and no cysts were to be found. After this operation the pulse quickly dropped twenty beats, the sickness of the stomach was relieved, and pain disappeared; the temperature fell a degree and a half, and the pulse continued dropping, until it reached 108 in thirty-six hours, with constantly improving general condition. It then began to climb again, and in forty-eight hours had once more reached 138, went to 150 and 160, with complaints of oppression, and pain in the right chest. In order to make certain that no lingering focus or sepsis remained in the abdomen, I once more irrigated the peritoneum with warm water, but without discovering any pus. The chances of recovery after this second rise in pulse, accompanied by rise in temperature, were very small; and the association of these factors with the complaints of pain in the chest, made the whole aspect of the case peculiarly ominous. Previously to this I had removed the stitches from the outlet, and found that it had healed perfectly throughout, affording one of the best closures I have ever made. The peritonitis after removal of the pus remained dry, the intestines had lost their lustre, and here and there were a few flakes of white lymp, like small shreds of curdled milk.

I have studied enough cases of peritonitis, watched with an anxious observance of the minutest symptoms, to speak with assurance, when I say that there did not remain sufficient cause in the peritoneum after cleansing to occasion death under ordinary conditions of vital force. The conviction was therefore unavoidable that the immediate cause of death, distress in the chest, and the rapid pulse, were due to clot forming in the great vessels. I remained by the bed-side myself all the last night, administering stimulants by mouth and hypodermically every fifteen minutes, until a late hour on the day following, when, with many fluctuations and short seasons of illusory apparent improvement, she died late in the afternoon, nine days after the first operation.

The bare outline of the case as above given stands thus: First, an operation upon the perineum and cervix, accompanied by a violent commotion of the abdominal viscera, due to the anæsthetic. Next, peritonitis distinctly recognized as such on the fourth day. Third, abdominal section for peritonitis, with thorough cleansing of the peritoneum and drainage. During the section a tubular canal was discovered, probably communicating with the umbilicus, a remnant of a fœtal duct. The secretion from the navel probably came through this, and was probably under the straining efforts forced into the peritoneal sac. After this operation and the drainage, prompt marked improvement, suddenly interrupted by the forma-

tion of heart clot, terminating in death, which was due therefore to a rare accidental cause undiscoverable prior to an operation.

MERCURIC CHLORIDE IN CHRONIC PARENCHYMATOUS NEPHRITIS.

BY THOMAS A. POPE,
CAMERON, TEXAS.

Case I.—F. H., aged 17, applied to me for treatment in April, 1882. Had been under treatment for several months before I saw him. As well as I could learn, the treatment had been anti-malarial. The eyelids and feet were slightly œdematous; the tongue coated; the bowels irregular, generally constipated, but occasionally there was diarrhœa; appetite capricious. Sometimes the patient vomited food; nutrition bad, as evidenced by flabby muscles and loss of weight; constant headache in occipital region; more or less pain in back, and a constant feeling of lassitude, and a very little exertion was very fatiguing; passage of urine caused a burning pain along the urethra.

On examination, I found the specific gravity of the urine to be 1035, and it contained about one-fifth its bulk of albumin. The quantity passed was about normal, but perhaps slightly reduced. As the patient had been taking quinine for months I gave him a mixture containing iron, arsenic and nux vomica, and also one containing bitartrate of potash and fluid extract of digitalis. This treatment was continued for a month without any improvement in the general symptoms or diminution in the quantity of albumin. I then prescribed:—

℞ Hydrarg. bichlorid.....gr. ij
Alcoholis q. s. to dissolve.
Ammon. chlorid.....gr. x
Aquæ menth. piperit.
Syr. simplic.....āā. f℥ ij
M. S.—A teaspoonful after each meal.

Also:—

℞ Potass. acetat..... ℥ j
Spt. ætheris nitrosi.....f℥ j
Aquæ.....f℥ j
M. S.—Teaspoonful once or twice every day.

I prescribed the mercuric chloride partly because I did not know what else to do, but principally because I knew it to be a tonic, an alterative, and useful in inflammations elsewhere, and that it would promote absorption of morbid growths when all other remedies were useless. I gave the alkaline mixture because I wanted the volume of urine to be large, and because I supposed that the pain caused by the passage of urine was due to its acidity, and wished to render it alkaline. Under this treatment there was, at the end of one month, a decided improvement in all the symptoms, and the amount of albumin was decidedly lessened. The alkaline mixture was discontinued, and from that time the patient took nothing but the bichloride solution and sulphate of magnesia, if needed, and some quinine on one or two occasions. At the end of eight months he was in the enjoyment of perfect health, and not a trace of albumin could be detected in the urine. To-day he is still in perfect health.

Case II.—In January, 1883, Mrs. B., aged 33 years, had an attack of acute parenchymatous nephritis. She was treated as usually directed for acute attacks of Bright's disease, and in about two weeks was apparently completely recovered. About three months afterwards I was called to see the same patient and found her suffering from chronic parenchymatous nephritis. I prescribed a bichloride solution, as in Case I, and gave nothing else, except a preparation of pepsin for digestive trouble and sulphate of magnesia when indicated. In three months the albumin disappeared and has never returned, and she has since enjoyed excellent health. Mrs. B. was not pregnant during the time she suffered from albuminuria, but has since given birth to two children.

Case III.—F. W., November, 1884, had been complaining for several months, and had taken a quantity of patent medicine. His symptoms led me to conclude there was some kidney trouble, and on examination I found albumin. This patient was put on the same treatment as the previous cases. For three months the albumin was constant; but at the end of that time it was lessened in quantity. The patient lived nearly twenty miles away, and had his prescriptions filled at home. At the end of two months he was able to work, and I did not see him for three months. He was then enjoying good health with no trace of albumin in his urine. I have not seen him since, but have heard he still enjoys good health.

Case IV.—W. N., aged 42, had felt badly for a long time, but did not apply for treatment until trouble with vision interfered with his profession of teaching. His eyesight was so bad that he could not read small print even with glasses, and small dark objects were constantly floating before his eyes. This patient was under treatment for eight months, and under my observation for a year longer. Under the use of bichloride of mer-

cury the albumin disappeared in five months, and perfect vision returned two months earlier. Since the disappearance of the albumin, he has been in perfect health.

Case V.—Mrs. F., was confined a year ago; I did not see her previous to her confinement. A few days after her confinement I examined her urine and found it loaded with albumin. From a history of the case I was satisfied that she had been suffering with albuminuria for at least two years. I put this patient on the bichloride, and she did not cease to take it until she was convalescent. About four weeks after her labor, she became partially paralyzed on the left side of the body and the right side of the face. In addition to the mercuric chloride she took strychnia, and opiates when indicated. Within five months she was convalescent, and has since been in better health than she had enjoyed for two years previous to her confinement.

Out of fifteen cases treated long enough in the past to be certain of results, I have selected five as illustrative of the whole. All of the fifteen cases recovered, and I know that eleven of the patients are to-day in good health, and the others were when last heard from. There were of course many symptoms present in these cases that are not given, simply because minute detail was not deemed to be necessary to illustrate the treatment, which was, as may be seen, very simple.

In all these fifteen cases the albumin was considerable and persistent for months. Albumin in the urine is not *per se* sufficient evidence to diagnosticate chronic Bright's disease, as its temporary appearance may be caused by violent exercise when the tissue waste is not converted into urea, by vasomotor disturbance in nervous persons, by congestion of the kidney, by ingestion of egg albumen, by various drugs, pregnancy, heart disease, and acute Bright's disease, and perhaps from other causes. But if we exclude these, and the albumin is persistent, then we may conclude we have chronic Bright's disease even if there be no symptoms pointing directly to kidney trouble.

But it is very rarely that we find persistent albuminuria without other symptoms to confirm the diagnosis. I am sorry that the lack of a microscope has prevented my making a microscopical examination of the urine in all these cases, as I then might have been able to make some definite observations on the pathological condition of the kidney in the patients treated.

As to the cause of chronic parenchymatous nephritis, while it has been ascribed to malaria, syphilis, alcohol, etc., there is no positive proof that these are direct causes. It is true that a patient with a weakened constitution from whatever cause would be more liable to acquire this disease than a man of sound constitution and in robust health.

Drs. Da Costa and Longstreth, in a paper which I have not had the pleasure of reading, state that in chronic Bright's disease there is found fatty degeneration of the ganglionic centers, and they think that the fatty degeneration of the renal ganglion is a cause of chronic Bright's disease. If this be true, it is a fact of great importance when we come to treat the disease.

The large white kidney is the kidney of chronic parenchymatous nephritis, and I think it probable that this kidney always precedes the granular or cirrhotic. Notwithstanding the fact that Bartholow and others state that interstitial nephritis is generally a primary disease, and seldom follows chronic parenchymatous nephritis, there is so far as I can find absolutely no evidence to confirm the statement. If we make it a practice to examine the urine of all office patients, we often find albumin when there is nothing in the symptoms of the patient that leads us to suspect it, and there are, no doubt, hundreds of persons suffering from chronic Bright's disease who appear to be in perfect health and complain of no trouble whatever. And if at the autopsy we find the granular kidney, what proof can there be that it was the primary, and not the secondary affection? There may have been no symptoms at all during the parenchymatous stage, and it may have been only after the interstitial tissue became affected and the kidney contracted that the renal trouble was developed.

Whether chronic nephritis follows the acute, or is always primary, is hard to determine. In one of my cases the chronic followed the acute form, but the patient may have been suffering from the chronic form before the acute was developed. If the patient was under observation previous to the acute attack, and no kidney trouble was present, it would be clear that the chronic followed the acute. But whether always primary or not the condition of blood and renal organs is the same when the chronic form appears.

Belfield and others state that nearly all cases of acute Bright's disease are of blood origin, and it seems reasonable to conclude that the chronic form originates in some blood dyscrasia or nerve trouble, and if by some remedy acting on the blood and nutri-

tion we can cure the disease it will be strong proof that such is the case.

The condition of the kidney cannot always be determined by the clinical symptoms. While general anasarca and a large amount of albumin and diminished urine is generally supposed to indicate large white kidney, and polyuria, little albumin and no dropsy, the granular kidney, the latter condition may often be found in the large white kidney.

It is of course the renal epithelium that suffers most in the large white kidney. The glomeruli show evidence of fatty degeneration, as well as the epithelium of the convoluted tubes. The lumen of the tubes may be closed by the coalescence of the cells. If there is no change for the better the interstitial tissue becomes inflamed and the granular kidney appears.

The solids of the urine escape through the convoluted tubes and Henle's loops, while the watery portion escapes from the blood in the glomeruli. I note this fact, because it has a direct bearing on the treatment. Anything which increases the pressure in the glomeruli will increase the flow of urine, as well as anything which increases the diffusibility of the blood. The urine is an index to the metamorphosis of the albuminous constituents of the tissues. This tissue waste is converted into urea and so eliminated. If not so converted it may appear in the urine as albumin.

Now let us look for a moment into the action of the mercuric chloride on the human economy.

Our knowledge of the action of this drug in the various troubles for which it is used is purely empirical, but the vast array of clinical facts has proved its value beyond any doubt. In some way it is certainly antagonistic to inflammation. We use it in iritis, hepatitis, and in all cases where there is a fibrinous exudate. Sir Henry Holland states that he has seen it promote the absorption of morbid growths, and change the character of morbid action in cases in which all other remedies had proved powerless. After protracted use of any preparation of mercury in large doses the blood becomes watery, and its solid constituents are diminished, and a large percentage is eliminated with the fæces; but in small doses it is a tonic and alterative, and most of it is eliminated by the kidneys. In small doses it aids nutrition in a remarkable degree, increases the glandular secretions, and increases the number of red blood corpuscles. Even small doses of the bichloride lower the arterial pressure, and of all preparations of mercury it is the least liable to salivate. I have used it in doses of 1-12 to 1-10 of grain three times a day for a year, and saw no signs of ptyalism. Corrosive sublimate renders the urine alkaline, increases the amount of urine and promotes the action of diuretics, probably by increasing the diffusibility of the blood.

Mercury acts by preference on the skin and mucous membranes; it is the most powerful antiseptic known. In mumps it will relieve the swelling and pain. Dr. Keyes states that even in healthy individuals the bichloride increases the number of red blood corpuscles, and those who give it in syphilis know that while taking it the weight of the patient increases, the nutrition is improved, and anæmia disappears. It promotes absorption of effused products in any part of the human economy, and is indispensable in some form in glandular enlargements, and is a valuable agent in fatty degeneration.

Those who have used this agent in the treatment of chronic Bright's disease because the patient was syphilitic, speak in high terms of its efficacy. Have they any reason to suppose that the disease is more easily cured when complicated with syphilis than when it is alone?

This article is too long already, and I shall leave the facts as I have collated them from various authorities to speak for themselves. In a future article I shall give my further experience, and in so far as clinical researches will enable me to do so, the various reasons for giving the bichloride in chronic parenchymatous nephritis; and in the meantime I shall be glad to hear from those who would object to the treatment and their reasons therefor.

CASE OF MALIGNANT DISEASE OF THE INGUINAL GLANDS; OCCURRING IN THE PRACTICE OF

M. L. HERR, M. D.,
LANCASTER, PA.

(Reported by Theodore Diller, M.D.)

Through the courtesy of Dr. M. L. Herr, I frequently saw the case here described, and I report it, by his kind permission, principally because of the interest attached to the diagnosis.

Jno. M., aged 22, tobacco packer, always enjoyed good health up to May, 1887, when he says he ruptured himself while lifting the end of a heavy wagon; he said he could distinctly feel something "give way," and that he could feel a tumor in his right groin which did not disappear when he laid down at night, except on *one* or *two* occasions. A

few days after the rupture appeared he procured a truss, which he wore about two months, although he complained that it never fit him properly, and caused him more or less pain. This induced him to get a new truss, which he did at this time; but he did not receive the comfort from the new instrument which he had anticipated. On the contrary, the pain steadily increased until the latter part of November, when Dr. Herr was called to see him. He had taken to his bed, and was, when first seen, lying on his right side with the corresponding thigh flexed upon the abdomen. Examination of the right inguinal region revealed the presence of a hard swelling about the size of an egg, just over the region of the external ring. The mass was firmly adherent to the tissues beneath, but the skin over it was freely movable. Handling the tumor caused the patient considerable pain. On being questioned closely he admitted that the enlargement was at this time distinctly greater than when the trouble began. He was kept in bed, and clay poultices were applied to the swelling, and opium was given internally. Diet was restricted. These simple means proved efficacious in relieving the pain and tendency to vomiting. The diet was then cautiously increased, and a tonic was given until January 10. During this time (six weeks) the tumor had distinctly increased in size, and the patient complained more of pain, while the diminution of body weight was quite noticeable. Moreover, the tumor had become more firm to the feel, and a peculiar dusky appearance of the skin over the growth, together with the above facts, made the diagnosis of malignant disease seem probable.

After consultation with Drs. S. T. and M. L. Davis, and C. E. Netscher, it was decided to remove the mass. The operation was performed by Dr. Herr, January 10. An incision was made one and one-quarter inches above and parallel to Poupart's ligament. Four tumors, ranging in size from a marble to a hen's egg were removed. The ring appeared normal, and no evidence of an entero-epiplocele or epiplocele could be found. The wound was packed with lint saturated with carbolized oil, which was renewed frequently —the wound always being cleansed thoroughly at each dressing with a solution of bichloride (1–2000). Notwithstanding these antiseptic precautions, the cut surface rapidly assumed a grayish appearance, and in a few days the bottom of the wound began to break down and form pus. It was, in fact, impossible to keep the room free from the unpleasant odor which constantly emanated from the part. On January 18, a small painful enlargement was noticed in the other groin; but the condition of the patient at that time was such that further surgical interference was out of the question.

As soon as the effects of the anæsthetic which had been used at the operation had passed away the patient began to vomit, and this troublesome symptom persisted until the day of his death—two weeks later. Cocaine, oxalate of cerium and carbonated water were given with the hope of allaying the gastric irritation, but all proved ineffective. The bowels were moved only with the aid of a purgative.

An autopsy was held twenty-six hours after death by Dr. Herr and myself. The wound made at the operation presented a uniform gray granular appearance. The internal abdominal ring on the right side, as well as the left, was altogether impervious, and they both resisted firm pressure of the finger. The intestines in both iliac regions presented a healthy appearance. In the *mesentery* was found a tumor the size of a child's fist—irregular in outline and light gray in color. Immediately surrounding this tumor in all directions, in radii of from one to one and one-quarter inches, was a mass of hard, gray indurated material. Along the entire length of the abdominal aorta, in some places entirely covering it, was a strip of soft gray structure, looking not unlike a racemose gland in appearance. There were a few lympathic glands along the aorta, which were enlarged, but had not fused themselves, as yet, so to speak, into this long, fleshy strip. The pancreas was enlarged, and attached to its superior border were two or three friable growths resembling the mass along the aorta. The *stomach* contained a small quantity of light-brown fluid. Mucous membrane was light gray in color. Along the greater curvature were three or four spots of fine ecchymosis. Near the middle of the greater curvature, about three-quarters of an inch apart, were two round ulcers. They were each about one-quarter of an inch in diameter, and both presented a "punched out" appearance, with clean cut edges, around which were small rings of congested mucous membrane. About one and one-quarter inches to the left of the nearest of these two ulcers was a small eroded spot—a little bigger than a pin's head—apparently the beginning of a third ulcer.

The *transverse colon*, instead of going directly across the abdomen just below the liver, assumed a V-shaped appearance. The

ascending colon reached the usual height and then turned upon itself and descended in a vertical line almost to the fundus of the bladder; it then ascended vertically to the left hypochondriac region to the point at which the colon receives the name descending. From here, in the remainder of its course, it was normal. The dependent portion contained a large amount of fæcal matter.

My friend Dr. A. J. Smith, to whom I referred the tumor taken from the groin, regards it as carcinomatous, but I myself rather incline to the opinion that it is a sarcoma—perhaps a lympho-sarcoma as suggested by Dr. H. F. Formad.

The case seemed to me to give rise to several interesting points in diagnosis, viz.: Did the man originally have a hernia as he stated, and was the enlargement in his groin occasioned by a simple adenitis and cellulitis, caused by an ill-fitting truss?

True, manipulation of the mass when the patient was first seen disclosed the fact that no hernia existed at that time, and that no amount of coughing would produce one. What then caused the somewhat painful swelling? Apparently it was not a bubo. The most likely diagnosis was that it was a severe adenitis caused by the irritation of a truss. But from this time, about November 25, until January 10, the general condition of the patient had deteriorated so markedly and the growth had increased so much in size that diagnosis of malignancy, at the latter date appeared most likely to be correct. I now think that the most plausible supposition is that the growth began *primarily* in the omentum, that the patient on discovering one day that there was a small movable painful lump in the groin, thought it was a "rupture." By pressing the enlarged gland into the external ring it would seem to "go back." Whether or not the wearing of a truss hastened the growth of the secondary tumor in the groin, it would be difficult to say, but the tumors in the abdominal cavity with the constitutional disturbance which they produced seem to me to be quite sufficient cause for the early fatal termination. The gastric ulcers can easily be accounted for by the fact that the stomach was, like all the other organs, in a very atonic condition, which as we know renders it prone to this affection. The general constitutional condition was also doubtless the cause of the curious anomaly of the colon which was noted.

—The second Congress of German Gynecologists will be held at Halle, May 24-26, 1888.

TWO CASES OF COLIC IN ADULTS, PRODUCED BY INTESTINAL WORMS.

STANLY M. WARD, M.D.,

ELLENVILLE, N. Y.

As is well-known, any irritating body within the intestinal canal is apt to produce that peculiar and excruciating pain called indifferently colic, ileus and enteralgia; that sometimes this complaint is due to worms is hinted at—sometimes broadly suggested by certain writers, but I am led to believe parasites are more frequently the cause of it than is generally supposed. I have also noticed in the course of a somewhat extensive reading, that very few writers, under the head of parasites, treat at length of colic as one of the most striking symptoms presented by those thus afflicted. Indeed, "worms" seem to have been relegated to the charge of "grandmothers," or else is treated from the standpoint of the naturalist.

I was called late one Saturday night, not many months ago, to see Mrs. O., the mother of a large family, who was somewhat neurotic, but withal a strong, hard-working woman. She complained only of intense pain in the stomach and abdomen—a pain which had came on suddenly about three hours before my visit. There was neither vomiting nor diarrhœa, no increase in temperature; pressure over the abdomen had no effect on the pain. There was no swelling or tumefaction; tongue clean, pulse slightly accelerated. The pain was said to be present constantly, but there were paroxyms during which my patient suffered most excruciatingly. Was it colic, produced by undigested food? Her supper had consisted of an oyster-soup with crackers, and her dinner had been light. It might be hysterical, though there were no concomitant symptoms. I administered an emetic of sulphate of zinc, and after emesis gave a large dose of asafetida with no effect. Having failed to get at the origin of the trouble, I treated her symptomatically with morphia and atropia, and after giving nearly a grain of the former, with one-quarter grain of the latter, the pain diminished. I cannot say just why I thought of worms as being the cause of the patient's sufferings, but there being nothing in her condition contra-indicating a vermicide, I began administering the fluid extract of spigelia and senna in drachm doses, and before noon of the next day had dislodged some twenty to thirty lumbricoid worms, with total and prompt relief. This woman is the

mother of five children, and her labors have all been severe; yet she told me that the "cramps" in her abdomen during that night were the most severe pain she had ever experienced.

Case II.—I have had two experiences with this patient. About four years ago she had a severe attack of colic, which was relieved only after she had passed fifty to sixty worms. The second attack occurred recently.

Mrs. N., German, a hard worker; she does washing. Her food is probably none of the best; she seldom eats meat, and lives chiefly on vegetables, bread and tea. Her daughter called at my office on the morning of March 15, saying that her mother had great pain in her belly. I sent one-quarter grain of morphine, and, suspecting the cause of the pain, also ten grains of calomel and one grain of santonin combined, with instructions to take it in half an hour after the the morphine. I was called during the afternoon, and found the patient vomiting; she had retained neither of the powders, and was in great pain. The abdomen was soft; no fever; tongue coated. One-eighth grain of morphine was administered hypodermically, and minute doses of calomel were left, with directions to take them in a little sugar, dry, on the tongue, every fifteen or twenty minutes. I saw her again about midnight; she had not retained a particle of the calomel. The morphine had given her some relief during the afternoon, but the pain in her abdomen was now most intense, the patient writhing and twisting as I have seen those do afflicted with biliary or renal calculus. She was vomiting quantities of a dark greenish fluid. She was then given an injection of hot soap-suds containing turpentine and castor-oil. Almost immediately her bowels acted, and three large, round worms were expelled. One-eighth grain of morphine was then given hypodermically. Early in the morning of the 16th I found her still suffering pain and vomiting the same greenish material. All attempts to administer anything by the mouth, even a teaspoonful of water, were followed by retching and vomiting. Morphine was again given hypodermically, and another enema of soap-suds with turpentine and oil; the latter brought away two more worms. During the day she had three-eighths of a grain of morphine in divided doses, hypodermically, and her bowels moved spontaneously, and there were five more worms in the ejecta. On the morning of the 17th I found no improvement to speak of in her symptoms. I then gave her a quart of a strong infusion of the root of spigelia and senna leaves by enema, and managed to get her stomach to retain two pills, each containing one-half grain santonin and one-half grain calomel. During the afternoon she passed twenty large worms, none of them less than eight inches in length. The symptoms now became somewhat ameliorated; the pain subsided so much that one-eighth grain of morphine, hypodermically administered, at 9 P. M., brought comparative rest for the night. The next morning, March 18, she took two drachms of the fluid extract of spigelia and senna, and during the day passed forty more large worms. Her pain now ceased, and in a few days she was herself again.

TREPHINING AN INFANT.

BY WALTER H. PARCELS,

LEWISTOWN, PA.

Something less than a year ago I was called to see a child, aged exactly seven and one-half months, which had been injured by a carriage rolling down an embankment.

The child's head had evidently collided with a stone. I found at the right parietal prominence a depression of the skull. There was no wound of the scalp, and the child's general condition was not greatly alarming. There was only *slight* tendency to coma, and its vigorous crying showed that "life's fitful fever" was not likely to end immediately; however, the cavity formed by the depressed bone was formidable indeed. It was by actual measurement 3 inches by 2¾ inches in diameter, and rather more than an inch in depth.

The skull being very thin, of course there was no fracture, and I need only to spring it back to its normal position. How could I do this? But little force would be required, provided that force could only be applied as a *vis a tergo*. While at my office for a trephine I slipped a gimlet in my pocket.

Drs. Dean and Atkinson kindly assisted me in the operation, which consisted in first exposing the bone by a T-shaped incision through the scalp. At the very bottom of the cavity I inserted the gimlet and pulled.

I was able to apply a considerable force in this manner, but not enough to elevate the bone. With the trephine I removed very carefully a small button at the same point.

I found a small opening through the dura mater from which oozed a watery substance. This hole had probably been made with the gimlet. With an elevator now applied behind the depressed bone I succeeded in

springing it back to its normal position. It flew back with an audible sound.

The wound was sponged out with strong carbolized water, closed with sutures, and for the next three or four days kept wet with cloths wrung out of carbolized water. No pus formed during the process of healing.

There was no fever, in short there was nothing to indicate that the child had undergone an operation. *Query:* was there a *better* way to elevate this depressed bone?

ADDRESS BY J. M. DA COSTA, M. D.,

AT THE DINNER TO DR. D. HAYES AGNEW,[1] APRIL 6, 1888.

Fifty years ago, on this very day, there stood, with the honors of a University just received, a young man on the threshold of his life. His thoughts were the pleasant ones of the occasion; his aspirations had hardly taken shape; he was the popular comrade of the hundred and fifty-five whose real life, like his own, was to begin. Fifty years have passed, and their Agnew has become our Agnew of the many thousands of the American profession.

Honored Guest:—In addressing you tonight I feel that I speak not simply for those who are gathered around you, nor for those in this Commonwealth whose interest will centre here, but for the whole profession who hold you in such esteem, and whose sympathetic thoughts, could they reach you, would come to you in messages of such goodwill and affection as to overwhelm you with their warmth.

Your career has been, indeed, a remarkable one; and you must pardon me, and let the occasion be my excuse, if in your presence I allude to its success, and to the main causes of that success. Nor is it wholly unfitting in one to do so who has known you and watched your progress with friendly interest almost since you came to this city, to try your powers in a wider field. The training you brought with you as a rural practitioner of note was indeed valuable. Self-reliance, cool judgment under difficult circumstances, are not the least reward of a country physician's hard life. You enrolled yourself as a teacher of medicine in its most laborious branch, and fittingly took charge of a school which has been the nursery of famous anatomists and surgeons,—where Godman's practical skill was displayed, and Joseph Pancoast laid the foundation of that intimate knowledge of the human frame which made him afterwards so great a surgeon.

This Philadelphia School of Anatomy, in College Avenue, has indeed left its mark in the history of medicine. It has been to us what the Windmill Street School was to the London of William and of John Hunter, of Hewson, of Cruikshank, of Baillie, of Benjamin Brodie, of Charles Bell. Its rickety structure harbored not only anatomists—some of them your own pupils, who were to succeed you as celebrated teachers—but its dingy walls heard eloquent discourses on diverse branches from more than one of your future colleagues; in its garret, independent and fruitful researches on the textures of the body were pursued; in its cramped lower room, physiological experiments were carried on, which have made their deep impress on the science of our day.

For ten years' working in this school of anatomy you lived laborious days and nights, and in its stern training your classes grew, until the narrow quarters would hold them no more, and you became the popular, admirable teacher you have proved yourself since, on a larger scale and on a different branch, as Professor of the Principles and Practice of Surgery in the famed University with which your reputation is forever identified. You learned to present facts plainly and impressively, to teach Nature's truths with Nature's simplicity, and without a deadly paralysis of words.

But in these ten years of unremitting work you did something more than teaching. You laid by exact knowledge, by steadiness of purpose and affability the foundations of that large practice which you have since enjoyed, developing every day, more and more, into the trusted surgeon whose deft hand and cool judgment caused his advice to be generally sought. Every country shows in its professions the national traits. You certainly represent as a surgeon, besides much skill, the American characteristic of resolute commonsense.

You have been tried in many a hard case. In none harder, than when your reputation caused you to be selected among the counsellors at the wounded couch of one for whose relief millions were anxiously watching. That in these trying times you bore yourself with the same calmness and dignity we know in you, every one in these millions recognized.

Your success as a surgeon of great repute must, indeed, have been gratifying to you. Not only for the opportunities it afforded you

[1] Given by the Medical Profession, in honor of the fiftieth anniversary of his entrance into the profession.

of doing so much active work in your profession; not only because it gave a personal value to your writings, especially to your opinions expressed in your elaborate work on Surgery; but because it enabled you to carry out a plan of action, of which I may not speak,—one which showed you to be possessed of the same high sense of honor for which Sir Walter Scott has received the unbounded admiration of mankind.

May you, dear sir, who have these many claims to distinction and esteem; may you on this, the fiftieth anniversary of entrance into a profession which you have graced by your industry, your sagacity, your skill, your character; may you accept the homage of those who are engaged with you in the same pursuit as a sign of widely-felt regard and appreciation. May your vigorous frame preserve your power of doing good, of teaching truths, for many a long year. May there always remain with you the assurance that, as age gently lays its hand on you, the chilling finger of time will not lessen the respect, nor benumb the tenderness of feeling, with which old and young alike regard you.

ON THE FORCIBLE FEEDING OF THE INSANE.[1]

BY DR. JULIUS RADER,

PHYSICIAN TO THE NIEDER-ŒSTERREICHISCHEN LANDESIRRENANSTALT AT YBBS.

Translated by A. H. P. Leuf, M.D.,
University of Pennsylvania, Philadelphia.

The following sketch of a fasting insane patient may be of general interest.

A. B., aged 39 years, single, formerly a wage-worker, is said to have been much neglected in childhood and to often have lived off food-refuse found in the streets. She is credited with having been addicted to various excesses, and was admitted to a Vienna hospital suffering with syphilis, where she disclosed symptoms of insanity, leading to her being transferred to three other institutions, of which the last was the Versorgungsanstalt at Ybbs. Here she remained rather apathetic till July, 1882 (eleven months after the beginning of her insanity), when she developed periods of excitement, during which she would break out in tears and occasionally shriek out the vilest epithets. She believed that she was being pursued and murdered by criminals, replied to no questions, and abstained from all food since September 20, 1882. Five days later she was sent to the Insane Asylum at Ybbs.

On admission she was filled with fear, but replied, though lazily, to questions. In answer to the query as to why she refused to eat, she said, "Because I have taken vitriol."

She is markedly congested, her pupils are very wide, the conjunctivæ are strongly injected, and there is *fetor ex ore*. Upon slight urging she took some food, and after the following day began to eat regularly. Otherwise she is quiet, indifferent as to her surroundings, and sits all day at the same place, and only occasionally talks to herself in an audible tone, scolding certain persons.

On Dec. 18, 1882, her face was markedly congested, she was excitable, says her bowels have not acted for several days, but refuses to take a laxative with the remark, "All will be well again if I eat nothing." Therefore, she abstained till Dec. 28, 1882.

In the following years, there was no appreciable change in her condition. She often had delusions of poisoning, claiming that her food had been poisoned so that she would become costive for a time. She would then abstain from food for from eight to twelve days.

In beginning of April, 1887, the patient again became more excitable, noisy, completely inapproachable, scolded continually, using the vilest expressions when approached or addressed, and also had delusions of poisoning. She abstained totally from all food from the 3d to the 24th of April. But during this time she drank considerable water, after taking which she would produce emesis by running her finger back in her throat. After this she would drink more water and repeat the emesis, and continue so many times during the day. Very bad *fetor ex ore* that fills the patient's whole room, and is readily noticed immediately upon entrance.

Patient took some food from the 24th to the end of April. She, however, abstained again from the 1st to the 16th of May, again drank large quantities of water, which she again expelled by self-induced emesis, lasting for hours. From the 16th of May to the 2d of June, 1887, she daily ate a little clear soup, but refused to take any more substantial food. In the beginning of June there set in an enormous, almost unappeasable, appetite.

The duration of the total abstinence and partial abstinence makes up a period of exactly two months. During this time the patient actually fed for only six days; the soup that she took daily from May 16 to June 2 can hardly be considered as food in any strict sense.

[1] Read before the Philadelphia Neurological Society, March 26, 1888.

The formerly very good-looking patient of finely nourished appearance had at last a sickly appearance, a dirty yellowish brown complexion, she was enormously emaciated, very weak, always sat crouching in the same place; during the later period was ever unapproachable, irritable and dejected, and scolded at once upon being approached. Weighings could not be undertaken.

Despite the long abstinence and the bodily deterioration of the patient therefrom resulting, in accord with the Director of the Institution, Dr. Langwieser, I did not proceed to to the artificial feeding of the patient.

The fact, on the one hand, that the patient on repeated occasions remained without food for a considerable time, and then spontaneously returned to food; on the other hand, the most sad experiences that I have had in the forcible feeding of patients during the last six years, gave me the courage to maintain a position of observation.

The question as to whether in a given case forcible feeding should be resorted to or not, is at the present time, despite good work in this direction, not yet ripe for discussion. At all events, the request for the forcible feeding of *every* abstaining patient after a given time, must be denied. Generalization is here least of all in place and every case must be accurately individualized.

The fear that these abstaining patients will die at the end of a week is unjustifiable, when we reflect upon the experience of the modern hunger artists or fasters. According to my experience, never to resort to forcible feeding of the abstaining insane, would entail less damage than the forcible feeding of all such cases. After having seen that many patients follow forcible feeding by violent emesis, and too often die of "Schluckpneumonie," due to the inspiration of vomited matter; and on the other hand, that patients, despite the ample ingestion of food that has been forcibly introduced, fail to assimilate it, and in a short time become enormously emaciated and eventually die, anyhow, not to mention those cases in which death results directly during the forcible feeding (partly because of the fault of a clumsy operator, etc)—these negative results must seem serious and be a cry of warning.

For the sake of comparison it may be well to say that at the present time forcible feeding of the insane is not much different from the not yet very distant past when these patients were much restrained. There was a time when the iron chain, with which the excited patient was fastened to the wall of a cell that in every way burlesqued all sanitary requirements, belonged to the necessary instrumentarium of the "expert in insanity;" and not far in the past is the time when it was considered urgently necessary to confine each new patient, whether quiet or not, in a straight jacket, or to apply it to excited patients for purposes of discipline.

It has taken a long time until this medical treatment was dropped in the service of true humanity, and restraint was resorted to to urge them, when other means were inefficient to prevent injury to the patient.

The danger to the abstaining patient consists in nothing but that of death from inanition; and so the only question to be considered is how long can the patient exist without food? One would believe that the diminution of the body weight might be sufficient; but the insane often overturn all theories and stand a loss of forty per cent. of the body weight without reaching the border of inanition. This then will not settle the question and other means must be resorted to for an answer.

We can only determine this, however, after more material has been studied from different standpoints, and especially that which considers the *etiology of abstinence*. Especially would it be necessary to consider the innervation of digestion that might, besides giving rise to indigestion, also cause hallucinations of taste and therefrom resulting delusions of poisoning, in which cases, because of the digestive power being dormant, forcible feeding could only do harm.

In the second place, there would have to be considered actual anatomical changes of the gastro-intestinal tract, as well as combinations of disturbed nervous innervation with pathological changes of the digestive tract.

Our case seems to be one of this kind. The behavior of the patient during her abstinence in filling her stomach with water and then emptying it by means of self-induced emesis, can be considered as perfectly rational and reminds one forcibly of the washing out of the stomach in cases of gastric catarrh.

It is certain that her own treatment did her more good than if she had been forcibly fed by means of the elastic-tube per nasum. —From the *Wiener med. Presse*, February 5, 1888.

—At the meeting of the Académie de Médecine, March 13, 1888, Dr. Lusk, of New York, was elected a Foreign Correspondent in the section of Surgery, by forty-two votes out of fifty-three. Sir William MacCormac received nine votes, and Mr. Victor Horsley, of London, two.

THE FORCIBLE FEEDING OF THE INSANE.[1]

BY JOHN B. CHAPIN, M. D.,

PHYSICIAN-IN-CHIEF OF THE PENNSYLVANIA HOSPITAL FOR THE INSANE.

The case which has been presented in the paper of Dr. Rader seems to be that of a person who, from some delusion, imposed upon herself periods of fasting extending, in one instance, to twenty-one days, during the years 1881 to 1887, inclusive, and for reasons which seemed good to the physician no forcible means for administration of food were resorted to. The study of this case leads Dr. Rader to question and condemn the practice of forcing food upon insane persons who will not eat, which he holds to be not only useless but dangerous, in which opinion the tenor of an editorial recently published in a medical journal concurs.

Every case of disease out of the ordinary course of experience has a lesson. If the physician in this case came to the conclusion that no great harm would arise if forcible means were not used to break the fast, he probably acted as the large proportion of physicians would or might act, and so far was justified in the wise course that he took. Fasting was quite the normal condition of this person, for she had accustomed herself to abstention from food at different times over a period of six years certainly, and there was no occasion to view her habit in this respect with alarm. If Dr. Rader had been accustomed to use forcible means whenever a patient refused to take food for a brief period, he might have obtained from his experience in this case a new and useful lesson, which others might wisely heed if they are too ready on all occasions to use force to feed an insane person. If he had not been accustomed to promptly administer food when refused by the insane, he might have fortified his radical conclusions by the citation of sad experiences, rather than by appealing to our fears and apprehensions.

First. "As to the question whether forcible feeding is not absolutely imperative in some cases," I must answer it from the standpoint of hospital experience alone in the affirmative. Eighty out of every hundred insane persons present the visible evidences of a lowered state of the physical health, ranging to extreme exhaustion, due largely to impaired nutrition, poor food and little of it. One of the marked changes in hospital practice in recent years, based on good experience and good results, has been the liberal administration of food as the most effectual means of restoration. About the question of alimentation in all of these cases no difference of opinion has arisen, and it is not presented in the paper of Dr. Rader; but what shall we do if the patient persistently refuses food, and in the judgment of the physician it is essential to the preservation of life and for mental recovery that the patient should take it. Shall we be content to do nothing more than to advise and urge the patient, or shall we resort to force? Here we must consider the fact that the patient has been placed under care because he is no longer competent to judge for himself, his mind is disordered, he is dominated by his delusions, and that the disordered condition may be mainly due to the impoverished state of the system. He is no longer competent to determine what and how much food he can or ought to take, what medicine should be administered, or what should be the management of his case. Yet he has certain rights, among them the right in his disordered mental condition to have his case wisely judged by his physician. Because of his insanity and his delusions, the insane person is deprived of his liberty that he may not endanger the community; so the insane are sometimes dangerous to themselves, and are placed under private care or hospital care that the strong will of another person may be substituted in place of a disordered will, and the responsibility of the case must be assumed by the physician, who cannot share it with the incompetent patient. The physician in general practice is sometimes confronted with this very problem in the management of his delirious cases, with absolute refusal to take food when considered essentially necessary, and I have never heard of the question being raised as to the propriety of the use of sufficient force to administer it in critical emergencies.

The term "forcible feeding of the insane" is not to be understood as always meaning the use of mechanical devices for this purpose (of which I do not propose to speak in detail), but it means the application of sufficient force (and not more than sufficient) by the physician, and under his sole direction and supervision to overcome the resistance of the patient, if resistance is made, and if not made, as it is not in the majority of cases, still to administer the required nourishment, notwithstanding the protests of the patient.

[1] Remarks made at the meeting of the Philadelphia Neurological Society, March 26, 1888, in the discussion of a paper by Dr. Julius Rader (see p. 498.)

In the hospital with which I am connected, I find that fifty-three patients have, at some period of their insanity, been fed because they refused food, and it was considered essential to the preservation of life or recovery that they should take it. Of the whole number, eight were fed with a nasal tube, and the remainder with a feeding cup or other simple device. The mental condition or delusions which seem to explain the refusal of food in these cases are presented in the following classifications:

General unsystematized delusions; and refusal to take sufficient food to sustain life, from obstinacy or absolute indifference;

Melancholia—refusal to take food to end life;

Melancholia with stupor and obstinate refusal of food;

Delusion—that patient was immortal and could live without food;

Delusion—That stomach and abdomen were full, and could not hold anything more;

Simple mental and physical enfeeblement with incapacity for self-administration of food or self-preservation.

Other reasons are sometimes assigned, and among them the alleged sufferings which food, taken into the stomach, produces, which deserved consideration, but I have assumed that the presentation of an actual experience would be more acceptable.

The patients embraced in these classifications may be grouped in two classes. We may place together those who from mental enfeeblement had not the capacity of self-preservation; they had no delusions, no mental activity, passions or desires, little vital force and a low form of animal existence.

They swallowed liquid food when placed in the mouth, sometimes resisting and sometimes not. Included in this group are cases of melancholia with stupor, who resisted whatever was proposed—they were silent—resisted the efforts to dress and undress, and refused food. They acted under the influence of delusions, the nature of which was not always manifested. Other cases of an opposite condition are placed in the same category—cases of mania that show great mental activity—ideas being formed with such rapidity that the patient's attention could not be sufficiently aroused and held to take food voluntarily, being too busy to eat, or they refused by reason of hallucinations of the senses of smell, taste and sight.

In the second group are placed those who refused food for suicidal purposes—those who entertained delusions of immortality—that life could in some way be sustained without food; delusions that food was poisoned; and delusions that the stomach was full and could hold nothing more.

None of these patients were fed after a single refusal to take food when offered, nor for the reason that abstinence from food was a violation of a hospital rule to which forcible compliance would at once be required. Not one was forcibly fed until the fast had continued from twenty-four to forty-eight hours, or even longer in those making the second class. When food was administered it was given because the actual exhaustion, as determined by the state of the pulse, tongue and history of the case was so great that life was imperiled, or when a state of delirious mania or melancholia with delirium was supposed to be due to exhaustion from want of food. In every case medical considerations alone decided the administration of food, and the physician acted as he always must act when grave responsibilities are laid upon him, according to the best of his judgment—more than that he cannot be expected to do.

It must be borne in mind that of all the abstainers, but eight were fed with a nasal-tube. The remainder took food from a feeding cup or otherwise, with some or no resistance other than holding the head and hands.

For thirty-five years I have either fed or directed the feeding of patients as seemed necessary, and I believe I speak within bounds when I assert that I could number by hundreds the patients who under my own observation, had recovered under forcible feeding, and that I have erred too often I fear in not commencing forced alimentation sooner than I did. Neither do I believe my observation and experience are exceptional, but the general rule, and what else have we on which to found a system of medical practice but experience? In view of these results which I am sure others will confirm, what warrant is there to condemn forced feeding as useless or dangerous. Physicians and surgeons are always taking chances, and must do so, and sometimes a patient has died under the influence of ether, yet no one will be bold enough to assert the practice of surgical anæsthesia is both useless and dangerous. Whatever may have been the experience of others, I have never had any unpleasant result or complication follow forced alimentation. Some years ago a suit for damages was commenced by a patient in a neighboring State, who alleged that the soft palate had been lacerated by a spoon in the hands of an attendant who was engaged in feeding her while under treatment in an asylum.

As to the time when feeding should be commenced, Dr. Tuke, in a paper read before the British Psychological Association, expressed the opinion that it should not be delayed more than twenty-four hours. Dr. Gray, in his practice, fixed the same limit. As to the general sentiment in the profession, I might here add that Dr. Savage, Dr. Clouston, Dr. Blanford, Dr. Spitzka and Dr. Sankey in their books, advocate the practice of prompt feeding and the administration of plenty of food. Dr. Westphal, of Berlin, and Prof. Ludensdorf, of Vienna, in their lectures, advise their students to resort to forced alimentation when necessary, and show to their classes the devices for this purpose. The French and Americans have expressed themselves in the same direction repeatedly in the medical literature of their countries.

Second. "Are there cases in which forced alimentation is not imperative, although patients refuse to take food?" To this question an affirmative answer is made. Occasionally we have to do with a patient who has some fixed delusion, is generally suspicious and apprehensive, but otherwise perhaps quite rational; there is no disorderly conduct; the general health is fair; and it may, on the whole, be the wiser course to let him alone intelligently, and not to interfere too actively with his individuality, trusting to the separation from home, and the influence of new environments to work some improvement. The delusion may have relation to the patient's food and lead to partial abstinence or complete abstinence for long periods. The patient will appear to be strong, and the mental vigor is not weakened. Here the question will arise whether or not more harm than good will come from the use of force to feed the patient —whether force may not sometimes unnecessarily aggravate or intensify suspicions and delusions, and I think we wisely refrain, in such cases, until a more positive medical indication occurs. I will briefly state a case that was under my care a few years ago, which furnishes a practical illustration of the affirmative of the second question. A clergyman, exhausted by his parish work, became melancholy—was regarded suicidal, as he meditated suicide and made one attempt. After admission to the hospital he seemed much concerned about the supposed failure of his clerical work. He spent several hours daily upon his knees, praying in an audible tone, and imposed upon himself brief fasts, until at last he partook of food but one day in the week, so far as the physicians were aware. No persuasion made any impression upon the patient. He entertained the delusion that only through a mortification of the flesh could he again obtain the favor of God and make good his repentance. He was resolute, conversed calmly, and when it was intimated that force might become necessary, begged that it might not be resorted to. Abstinence from food, partial and total, had now continued for a period of four months, and the question of the use of force was the subject of daily discussion and anxiety. At the end of this period a clerical consultation was had and a clergyman visited him daily. The force of the delusion at length abated and food was taken on alternate days, and afterwards daily and freely, with the result of gradual improvement and complete restoration. This gentleman has now been engaged in his ministrations to a large parish more than twenty years. I have never regretted the conservative course that was pursued in his treatment, and have had repeated evidences of his friendship and confidence, which is not always the case in our relations with the insane.

The answers to the two questions which the paper that has been read seem to suggest, go to show that no absolute rule can be laid down for our guidance in every case, but that we must apply to each our experience and best judgment. I have purposely refrained from any allusion to the medical treatment of conditions in which delusions are present, the removal of which would change the repugnance to food which so often exists, but have confined myself to the question suggested by the paper which has been read.

—Dr. Seavor, director of the Yale gymnasium, has just completed the physical measurements of the sophomore class, and has developed some very interesting facts concerning the effects of training. All but four of the class have made decided physical progress during the year, although only a small proportion of the class have taken a regular course of training. The most noticeable increase in the measurements have been in height, girth of inflated chest and girth of head. A very notable example of the effect of light exercise is in the case of a man who, during the year, without the aid of any regular course training, has developed more than any one in his class. His gains have been: In height, 1½ in.; chest, 2 in.; calf, 1 in.; biceps, 1½ in.; forearm, ¾ in.; breadth of shoulders, 1¼ in., and in the capacity of lungs, 40 cub. in. Three have given up tobacco during the year, but the smokers are 5 per cent. in excess of what they were last year.—*Ledger*, February 24, 1888.

Society Reports.

PHILADELPHIA NEUROLOGICAL SOCIETY.

Stated Meeting, March 26, 1888.

The President, S. Weir Mitchell, M. D., in the chair.

In opening the discussion upon the subject of the

Forcible Feeding of the Insane,

introduced by the translation of Dr. Rader's paper[1], and by the paper of Dr. John B. Chapin,[2]

Dr. S. Preston Jones, of the Stockton Sanitarium, Merchantville, N. J., said he had never seen any serious results from forcible feeding. He found it necessary in about one out of every one or two hundred cases. Some patients refused food because there was actually no appetite and a loathing of food. These patients were in bad health, and in such cases forcible feeding he thought did harm and the patients would mostly die at any rate. If the patient was in good general health and refused food, he did so because he thought that it was poisoned. It could be forcibly administered, and digestion as a rule was good. He had seen such patients steadily improve under such a course and sometimes get well. Patients sometimes had queer reasons for refusing to take food. One man under his care had told his wife as she was about leaving him, that he would never eat a mouthful in the hospital. We let him go for a week or ten days and then began to use the stomach-pump. He soon began to improve and would have gladly taken food had it not been for the fact that he had made a vow not to eat voluntarily. At the end of three months he left the institution restored to health. Another of our old patients was very fastidious about his food and unless he got just what he wanted he would not eat. This became troublesome and on one occasion we used the pump, not in the gentlest manner. And there was no further trouble.

Formerly the stomach-pump and tube were used, but he now employs the nasal-tube. This was easily done, did not injure the œsophagus or stomach, and the food passed into the stomach much more slowly than with the pump. He thought that possibly some damage might be done by pumping a large quantity of fluid rapidly into the stomach. The use of the stomach-tube was sometimes done in a rough matter, causing much discomfort. The mouth had to be forcibly opened, and sometimes this was a serious matter.

Dr. Jones had never before heard of a patient being strangled under the operation. He thought that formerly patients were often forced to take food too soon. At one time it was taught that the patient should not be permitted to go more than one or two days without taking food. He now had a patient who was rapidly recovering, who had been fed twice a day for six months. He had not the slightest doubt but that he would have died if he had been left alone.

Dr. E. N. Brush, First Assistant Physician in the Male Department of the Pennsylvania Hospital for the Insane, said that it had been his habit for the past ten years in the two hospitals with which he had been connected to use forcible feeding. He had employed the nasal-tube, the stomach-tube and injections. He had never regretted feeding a patient, but had sometimes regretted that he had not done it. He thought that sometimes patients were not fed soon enough, and not often enough when we do feed them. In some hospitals the routine custom was to feed two or three times a day. He thought that in some cases it would be better to give smaller quantities six or eight times a day. It was an easy thing to use the nasal-tube, or if there was some deformity of the nose, or other reason contra-indicating its use, the mouth could be readily opened if we went about it in the right way. It had been said that if the patient was a lady, the best plan was to get her to talk. In other cases, the index finger could be passed between the cheek and the teeth and inserted behind the last molar, and the jaws could then be separated.

The importance of this matter should be impressed on the general practitioner. We frequently see cases reported in the newspapers where death has resulted because artificial feeding had not been employed. Physicians had a fear of this simple and ordinary operation. He frequently used the tube as a siphon, the tube being provided with a bulb by which the flow might be started. A similar arrangement might be used for washing out the stomach in cases of poisoning. The bulb was without valves, these being extemporized by the operator's fingers. In a certain proportion of cases washing out of the stomach as part of the feeding operation—the washing being done some time before the introduction of food—resulted in an improved condition of that

[1] See Reporter, p. 498.
[2] See Reporter, p. 500.

organ and a voluntary resumption of eating.

Almost all of the ordinary articles of food might be given through the tube. Mashed potatoes could be given if mixed with a little milk and some preparation of malt. The same might be said of the farinaceous foods. Powdered beef and other preparations of meat are easily administered.

Dr. Brush on more than one occasion fed patients by the rectum. When the stomach rejects food, or when the injection of food caused pain, this method deserved a trial. He had employed various articles by this method. Some years ago he tried defibrinated blood. It acted satisfactorily, but gave rise to such an offensive odor that it was discontinued.

Various methods had been suggested for the feeding of patients. One of the most striking was that proposed by an Italian physician. He suggested that the food be prepared in the form of a bolus, which was placed in the back of the pharynx, and then an electric current was passed through the neck, causing the mass to be swallowed. He claimed to have accomplished this.

The length of time that a patient can be kept in good condition by forcible feeding probably depended upon the other conditions present. He saw a patient of Dr. Yellowlees, in Scotland, who had been fed daily for six years, and was still in good condition. He had fed a patient for eighteen months. The patient was then transferred to another hospital, where at last accounts she was still being fed. Dr. Westphal preferred the use of a funnel with a stomach-tube. So do some of the other German authorities. Some of the English alienists still use the stomach-pump. Dr. Yellowlees used a bottle with the tube attached to its side, at the bottom.

In the matter of tubes, Dr. Brush's preference was for the soft rubber ones. For nasal feeding he used a soft rubber catheter, with the opening in the end. He had various sizes of stomach-tubes of the same material.

Dr. J. C. Hall, Physician-in-Chief of the Frankford Insane Asylum, Philadelphia, said the ground seemed to have been pretty well covered by those who had taken part in the discussion. He must say that he did not agree with Dr. Rader in regard to the advisability of not feeding. He had never seen any bad results from the practice, and he thought that a mistake was often made in waiting too long before beginning forcible feeding. He should not like one of his patients to go more than twenty-four hours without taking food if he thought his condition required it.

At the present time, they had an epidemic of not eating in the institution with which he was connected. About ten per cent. of the cases refused to take food. He found that one with a good deal of strategy will influence others to follow his example. Some he thought had taken up the matter by imitation. He employed the nasal-tube, although he preferred the stomach-tube where it could be used without too much annoyance, on account of its greater rapidity. He used with this a funnel. The only objection that he had met with was that the patient would occasionally regurgitate the food. He thought that the main thing to be taken into consideration was not to allow the patient to go too long without food. He recalled one case of melancholia in which food was refused under the delusion that it was poisoned. This patient was fed three or four times a day for eight or ten months, and finally recovered, left the hospital and went into business. He has seen many other cases in which the advantages of forcible feeding were clearly illustrated. Dr. Chapin had well covered the ground, and he agreed with him on most of the points presented.

Dr. J. Willoughby Phillips, of Burn Brae, Clifton Heights, Pennsylvania, said that during the past ten years he had had about fifteen cases in which forcible feeding was called for. He had never seen any accident; the only untoward occurrence that he had known of was a convulsion during the passage of the stomach-tube. He had used both the stomach and nasal-tube, and either can be employed with ease if properly managed. He used the tubes simply with a funnel. He had then in charge a lady who had not taken food voluntarily since a year ago last December. The nasal-tube was used twice daily during the entire period. She had not gained in weight, neither had she lost. During the operation the patients should be so thoroughly under control that there can be no possible chance of their injuring themselves or interfering with the operation. This can be accomplished by having plenty of assistance.

Of the foods used in such cases, milk and eggs head the list; with these may be combined beef tea, mutton broth, and strong consommé, vegetables in liquid form, and occasionally extracts of malt and spirits, according to the requirements of the case. When patients are debilitated and run down, prompt and liberal feeding is clearly indicated. His practice was to administer nourishment twice daily, the amount being at least a pint and a half at each meal.

Dr. William Osler said that in general practice he often had occasion to feed patients with the tube. In the course of some years' observation in the post-mortem room, he had seen three or four instances of deglutition pneumonia, such as had been referred to in the paper. He saw such a case not long ago. A girl was admitted to the hospital in a comatose condition, and it was necessary to feed her with the nasal tube. At the autopsy a double deglutition pneumonia was found. It was extremely important that the operation should be properly performed. The tube should be entirely emptied before it is withdrawn, and taken out carefully. In the insane, accident is not so likely to result, for the patient generally coughs the foreign matter from the larynx, but the comatose patient does not recognize it, and the fluid passes into the bronchial tubes.

Dr. E. N. Brush said that the danger to which Dr. Osler referred should always be borne in mind. His invariable custom was to pinch the tube if it was soft, or if it was stiff, to place his finger over the opening while removing it. Dr. Hall had referred to the fact that he had had an epidemic of refusal of food. It was found that if other patients knew that there was a patient being fed with a tube there would soon be other cases, especially among those of a hysterical tendency. A curious fact may be mentioned that many of the cases which refused to eat, would eat if they had a chance to steal sufficient to live upon; and acting upon that, he had often avoided the necessity of feeding, by directing the nurses to leave food where these patients could surreptitiously gain access to it.

Dr. Charles K. Mills said that he regarded the subject of the forcible feeding of the insane as one of great practical importance to general practitioners of medicine, as well as to those who had charge of the insane institutions. When he read in the Medical and Surgical Reporter the favorable editorial comments on Dr. Rader's paper, advocating non-interference when insane patients refused food, he felt that the subject would be an excellent one to bring before an association like the Philadelphia Neurological Society, which counts among its members neurologists, alienists and general physicians. He did not, however, feel that he could add much to the discussion; but he would like to emphasize the importance of forcibly feeding the insane who are treated at their homes, or not in institutions especially intended for such patients. He saw many cases of insanity in consultation, and was frequently called upon to treat such patients at their homes, either alone or in connection with other physicians. He could recall a number of cases of acute mania, melancholia, delusional monomania, and stuporous dementia, in which he was confident that fatal results, or absolute failure to succeed in treatment at home, were due to carelessness or tardiness or indifference as regards forcible feeding. Occasionally cases of hysterical insanity will either intentionally, or in spite of themselves because of their morbid impulses, carry their refusal of food so far that their stomachs will not respond properly to the stimulus of food when given, and serious results will then ensue. He had had under his charge for several years an intelligent young man, but the unfortunate victim of a form of paranoia, chiefly exhibiting itself in abulia, inchoate delusions, and imperative conceptions, nearly all circling about a fundamental delusive idea with reference to the sinfulness of having blood entering in any way into his food. This patient was fed 400 to 500 times forcibly with the œsophageal tube in the course of about two years. Dr. Mills had but little doubt that his life was saved by the procedure; and not only so, but, as the patient himself had more than once declared, the forcible feeding had probably prevented him from passing into a state of acute mania, great excitement having frequently resulted from the terrible conflict precipitated by the struggle between the desire to take food owing to pressing physical necessity, and the resistance to the inclination by which he was delusively dominated.

As to the methods of feeding by force, his experience was in favor of the nasal-tube. As this discussion was intended in publication to cover the subject of forcible feeding, he would close his remarks by quoting from his little book on the "Nursing and Care of the Nervous and the Insane," a few remarks on this subject of nasal feeding: "The number of patients who cannot be fed by the nose is very small; occasionally, however, a patient is found whom it seems impossible to feed in this way, owing to the choking and strangling produced. This may be because of some peculiar anatomical conformation, or some special idiosyncrasy on the part of the patient. Such a patient will choke or strangle with nasal feeding when he will not when the stomach-tube is resorted to. If, when the attempt is made to pass the well-oiled tube through the nostril, resistance is encountered, and if, after a few trials, the tube cannot be made to pass, great force should not be employed by the operator, but the tube should be at once with-

drawn and the effort should be made to pass it through the other nostril. In nearly all cases where special resistance is offered on one side, the tube will pass with ease upon the other, and this, in most instances, is because, if hypertrophies or projections exist upon one side, there will be upon the other corresponding or compensating depressions and enlargements. Sometimes, but rarely, the mucous membrane is exceedingly irritable. After the nasal-tube has passed through the nostrils, it seems to have a peculiar tendency in some cases to drop into the glottis, the patient struggling and attempting to scream meanwhile. Some patients will spit or force the tube out into the mouth; and attendants can sometimes through the mouth, keep the tube, which has been passed through the nose, in position. Occasionally the nose is made sore by the use of the tube, but this is not likely to occur if the tube is always perfectly cleaned and well oiled. If it is of the proper kind; that is, a soft tube, there will be no danger of injuring the parts by breaking or perforating the mucous membrane. In using the nasal-tube, great care should be always exercised to see that at least fifteen to sixteen inches of the tube has been passed before beginning the feeding. This will make it certain that the entrance to the windpipe has been passed. Of course care should be taken to observe that the tube has not doubled itself." He would add one remark, namely: Great care should be taken not to administer the food too hot. He knew of one accident occurring in this way.

Dr. S. S. Shultz, Physician-in-Chief of the State Hospital for the Insane at Danville, Pennsylvania, sent the following letter to Dr. Mills as his contribution to the discussion:

Danville, Pa., March 23, 1888.

My dear Doctor:—I give you herewith, as requested by you in your favor of the 17th inst., briefly my views in regard to the forcible feeding of the insane.

1st. Is it ever absolutely necessary to administer food against their will to any class of the insane? Is life prolonged or restoration to reason promoted by such a course of treatment? It must be admitted that this question does not allow a mathematical demonstration either way. It is easy to claim when bodily health is restored or the mind improved under compulsory feeding that this would have happened without such treatment, or when death occurs, or insanity becomes chronic, under the expectant plan that such results were inevitable. In medicine, few problems could be solved by such a method of reasoning. The majority of patients who come into hospitals, from country districts at least, suffer from impaired nutrition. Until there is improvement in the pasty tongue, the want of appetite, anæmia and emaciation, it is in vain to look for improvement in the symptoms of insanity. Impoverishment of the blood seems to be the condition which gives many of the so-called causes of insanity their importance. These may be incurable, as, for instance, the remains of injuries to the skull, or disease of the heart, and yet if the nutrition can be improved and the blood enriched, the mental disorder often for a time disappears. When the insanity is the result simply of defective nutrition, progress towards permanent restoration keeps pace with the improvement of the blood resulting from better nutrition. If this torpid condition of the nutritive functions is permitted to remain a long time, the irregular mental habits become chronic, and the risk of incurability rapidly increases.

This much to show my deep convictions that poor blood plays an important part in the causation of many cases of insanity, and that the prompt correction of this will give the best chances of recovery. A German writer defending the expectant plan, sees no danger in fasting when it is not prolonged over fourteen days without taking water, not over fifty days when water is taken, nor so long as 60 per cent. of the body weight remains. The practice of such a rule or anything approaching its extremes, it seems to me must lead to the sacrifice, not only of the chances of recovery, but of life itself. It can certainly not be the part of wisdom to allow the boat with its living human freight to drift to the very brink of the cataract, without attempting to arrest it at the beginning of the rapids, where it can be done with so little risk.

Insane patients having organic disease of the digestive apparatus as inflammation of the pharynx, or cancer of the stomach, are likely to refuse food earlier and more persistently, than the sane in similar conditions, and the measures suitable for those whose fasting is the result of delusion, need modification for these. The melancholic who fast from religious or suicidal motives, or the delusion that there is no room for food, or that the passages are closed, most often carry their purpose to a dangerous extent, and thwart persuasion, reasoning, coaxing, no matter how skilfully or persistently plied. No rule based on the element of time of fasting is applicable; but as there has

been usually for weeks an insufficient amount of food taken, it is safe to begin the feeding as soon as the purpose of abstinence has shown itself to be settled, and refusal to yield to other resources, and both bodily and mental symptoms become worse. The more the character of the patient while in health was marked by resolute purpose and stubbornness of will, the less likely is delay to be of any use.

Of course food introduced into the stomach in this mechanical and compulsory manner is of less value than when taken at the prompting of natural hunger, but one must choose the lesser of two evils.

Nutritive enemata may answer for a time when fasting instead of being the result of a fixed purpose has its origin in the loss of the feeling of hunger.

Patients suffering from melancholy no doubt most often require artificial feeding, but other forms of insanity may demand the same treatment. When no physical condition can be detected that would justify abstinence, the forcible administration of food should not be delayed to the point of starvation in any form of disease. When emaciation has surely set in, the breath has become characteristically heavy and foul, and the strength is diminishing, active measures should be no longer postponed, when the will of the patient cannot be persuaded.

With reference to the manner of carrying out the indication, little need be said, as the nasal-tube is now universally preferred to that by the œsophagus. It has the advantage of making resistance less possible; and injury to the teeth and soft parts cannot occur.

It is possible that the tube may enter the larynx through an awkward position or movement of the patient. If the tube is pervious and haste is avoided such a misadventure will be defeated through the restlessness of the patient and the escape of the air through the outer end of the tube.

Very truly yours,

S. S. Shultz.

—There is a hospital in Chicago which contains the following article in its constitution:

"All medicines used in the hospital must be prepared without alcohol, and all physicians accepting positions on the medical staff of the hospital or dispensary must pledge themselves not to administer alcohol in any form to any patient in the hospital or dispensary, nor to call in the counsel for such patients any physician who will advise the use of alcohol."

Periscope.

Embolism of Right Axillary Artery Connected with Mitral Stenosis; Gangrene of Forearm.

At a meeting of the Clinical Society of London, January 27, Dr. Burney Yeo related the case of a woman who was admitted under his care into King's College Hospital in December, 1886, with great pain and loss of power in the right hand and arms, which came on suddenly, accompanied with giddiness. The fingers, hand and forearm on the right side rapidly became white, and motion and sensation were completely lost. She had had acute rheumatism, and suffered from dyspnœa on exertion. No pulsation could be felt in the radial, ulnar or brachial arteries in the right side; pulsations could, however, be felt in the subclavian. The cardiac action was rapid and irregular, the impulse and sounds were very feeble. The patient also suffered from cough, dyspnœa and great restlessness. In a few days the forearm became blue and mottled, subsequently black, and dry gangrene set in. Opium was given to allay the severe pain and restlessness, and iron, quinine and digitalis to improve the cardiac tone. As the ventricular contractions improved in force and regularity, a distinct, though feeble murmur could be detected which appeared to precede the impulse. After consultation with Sir Joseph Lister it was determined, as soon as the cardiac tone had sufficiently improved from the administration of digitalis, to amputate. This was done, about the middle of the upper arm, by Sir Joseph Lister, under chloroform, on January 14. The patient recovered well from the operation, but two days afterwards pneumonia with pleuritic exudation occurred on the right side, and she died somewhat suddenly on the 19th. *Post-mortem* examination showed considerable constriction of the mitral valve, and a large, old and firm clot in the left auricular appendage, from which, no doubt, the embolus in the axillary artery proceeded. Hemorrhagic infarctions were found in the right lung, and considerable effusion of serous fluid and lymph in the pleural cavity, and on the surface of the lung. The kidneys also contained old, small white infarctions. Examination of the stump showed the primary clot to be situated just at the beginning of the axillary artery. Dr. Yeo added some comments on this case and its management.—*British Med. Journal*, February 4, 1888.

Normal Course of Puerperal Temperature.

The *Practitioner*, February, 1888, publishes the report of a Committee appointed by the Æsculapian Society to study the normal course of puerperal temperature. The report concludes as follows: The deductions which may be drawn from these investigations seem to be that in a large number of cases, as we should expect would be the case in a purely physiological act, labor and the lying-in period are free from any marked fever; but that at the same time the whole system, and especially the mental system, is in a state in which it is very ready to receive impressions from without, and that any reflex irritation or any mental excitement causes a rise in the temperature which may be most marked, but which ceases on the removal of the cause.

Photoxyline in Surgical Practice.

Von Wahl (*St. Petersburger med. Wochenschrift*, No. 20, 1887), says that a five per cent. solution of photoxyline, in equal parts of alcohol and ether, can be differentiated from collodium by the following properties: 1. Persistent firm adhesiveness to the skin. 2. Absolute imperviousness to fluids. 3. Uniform compression of the tissues.

Photoxyline is suitable for: 1. Minor operations among walking patients. 2. Plastic operations upon the face and in the neighborhood of the male genitalia. Over wounds closed with sutures there is placed a thin layer of absorbent cotton saturated with photoxyline. In children, where the soaking of the dressing is not to be avoided, this painting proves a sure antiseptic protective. 3. For laparotomy, any further dressing of sutured wounds is superfluous, and the belly-wound is secured in the best manner. — *Deutsche med. Wochenschrift*, Dec. 8, 1887.

Case of Chronic Sulphur Poisoning.

In the *Berliner klin. Wochenschrift*, No. 42, 1887, Eichbaum reports the case of a man 37 years old, who has been using continuously for eight years a sulphur ointment on his scalp, which was affected with a very copious formation of scales. The pomade was employed every second day, and about three and a half ounces are supposed to have been used. The symptoms began with a feeling of stiffness in the neck; the face was pale, and the brow covered with sweat. Both pupils were dilated, and did not react either to light or to an irritation of the skin; the tongue was somewhat tremulous. The head was drawn a little to the right and behind, and the muscles of the right half of the neck, especially the superficial muscles, felt specially hard and tense. By the exercise of repeated powerful movements of the head, the rigidity gradually yielded. The patient complained of pain in the back part of the head, of a disposition to vomit, and oppression in the chest, and slight tenderness upon pressure in the epigastrium. The pulse was 124, and very small; respiration 16. After a rather restless night his condition improved. It was ascertained that the patient had suffered from headaches before, which were subject to exacerbations at irregular intervals. An attack similar to the one just described had occurred some weeks before. Eichbaum supposes that the patient was poisoned with sulphuretted hydrogen, as under the influence of fat and heat a decomposition of the ointment takes place, with the formation of sulphuretted hydrogen. The latter he supposes entered the body in part through the scalp, and in part through the lungs.

The patient was advised to discontinue the use of the ointment entirely, and to take a course of warm baths, abundant exercise in the fresh air, and the like. The symptoms of the disease gradually subsided, and in about four weeks there was no sign of the the disease to be seen.

Phosphorus in Typhoid Fever.

Aycart writes to the *Revista de Sanitad militar.*, July, 1887, recommending phosphorus both as a tonic and as a stimulant. He employs an ethereal solution containing one-third of a grain of phosphorus to one fluid drachm of the vehicle, and prescribes this dose in two parts, taken daily in a glass of Malaga wine. In two cases in which he has used it, he has obtained, he says, satisfactory results. The first case was characterized by an irregular fever, and by delirium and collapse. In this condition, phosphorus within two hours brought about regularity of the pulse, sleep, return of consciousness, and finally, in a few days, the normal course of the disease. The second case is that of a patient in whom stupor was extreme, the fever high, and the course of the disease irregular. Toward the fourteenth day, the temperature suddenly fell 3.8°, and fatal collapse threatened. Aycart then prescribed phosphorus. Several hours afterwards, the threatening symptoms had disappeared; the next day the patient began to improve steadily, and then became convalescent. He recovered.—*Gazette Hebdomadaire*, January 13, 1888.

Tubercular Disease of the Testis as a Local Affection; Desirability of Early Castration in Certain Cases.

The basis of this paper, which was read at a meeting of the Royal Medical and Chirurgical Society, Jan. 24, 1888, was a record of five cases of tubercular disease of the testis which came under the notice of Mr. Wm. H. Bennett amongst his out-patients at St. George's Hospital. The cases were selected with great care from a considerable number of patients suffering from this disease, as they possessed the following important characteristics in common: 1. An absolutely perfect family history, and an entire absence of evidence of privation, excess, or other conditions predisposing to the development of tubercular disease. 2. A perfectly clean bill of health up to the time of the onset of the disease in the testicle. In this respect exception might perhaps be taken to the case of patient No. 5, who had suffered from syphilis twenty-three years previously, but had never been troubled by any symptoms since. 3. The cause of the original inflammation in the scrotal contents was due in all the cases to direct local irritation, traumatic in four, gonorrhœal in one. 4. In each case the spinal column showed evidence of disease before the opposite testis, epididymis, either seminal vesicle, or other parts in the immediate neighborhood of the testis originally involved. The spinal disease was so insidious that, with the exception of case No. 3, in which it was discovered accidentally, its existence was not suspected by the patient. 5. In none of the cases did the affection manifest itself in other parts until after the original disease had broken down. These points were fully discussed, and the following propositions submitted: *a*. Inflammation of the testicle or epididymis, the consequence of injury or direct irritation, might result in tubercular disease of a purely local kind, which if left to itself, tended surely to generalization. *b*. The greatest tendency to general infection was at a time subsequent to the breaking down of the original disease. *c*. Parts remote from the testis originally involved might be affected before the opposite testicle, epididymis, or either seminal vesicle. *d*. The rational treatment of cases like those under discussion was castration, upon the appearance of disintegration about the original disease—that is, at the commencement of what the author termed, for reasons stated, the "dangerous period." Mr. Bennet subsequently explained that he had not meant to imply that what he described was the common course of tubercular disease of the testis, but merely what had actually happened in 5 cases out of about 150, from which he thought there was something to be learnt as to the method of diffusion and the mode of arresting it. The symptoms referred to the spine were beyond what could be caused by inflamed glands. In one case there was carious bone shown at a *post-mortem* examination; in another the spinal curvature was half as large as his fist; in a third the stiffness extended up to the upper dorsal region; in a fourth the spinal symptoms had improved, but relapsed, with spread of the disease to the other testis. Mr. Clutton's case was dissimilar in having a nodule in the cord, whereas his own point had been to advise operation before the formation of a nodule in the cord. It certainly needed some practice on the living and the dead to acquire a thorough practical knowledge of the condition of the vesiculæ seminales and the prostate in health and disease, and he had ventured to bring this subject before the Society as raising the question of the method of diffusion of local tubercule and the opportunities of stopping it.—*Brit. Med. Journal*, January 28, 1888.

Management of Children's Teeth.

Professor Miller, of Berlin, in an article on the milk teeth, published in the *Therapeutische Monatsschrift*, No. 2, 1888, points out the evil effects on the teeth of sugar and other substances which undergo fermentative changes. A child, he says, is constantly eating sugar and substances containing it, and though the particles of food are more likely to get between the teeth and set up caries than in the case of grown persons, children never, or at least very rarely, have their teeth cleaned. He would insist upon proper cleaning twice daily, a very soft brush and a weak disinfecting dentifrice being employed for the purpose. Sweetmeats should be entirely prohibited or their use very carefully supervised. Barley sugar he does not consider so injurious as chocolate and soft clammy sweets, because the former is more soluble. It should be remembered, too, that starchy substances soon become converted into grape sugar. Prof. Miller suggests that after a child has eaten the barley sugar, its mouth should be washed with water. All decayed teeth should be filled at once, even in the case of children under three years of age. All children's teeth should be attended to from the very beginning.—*Lancet*, February 11, 1888.

Case in which there were Numerous Fractures at Birth.

In the *Archiv für Gynäkologie*, Bd. xxx, Heft 2, Dr. Paul Linck reports a case in which there were numerous fractures of intra-uterine origin. The fœtus was expelled in the membranes spontaneously in the thirty-second week of gestation, and died of asthenia 27½ hours after birth. The mother was a primipara, 22 years old. In the left thorax there were about forty, in the right about forty-four fractures. The fractures were in part united with callus. The sternal ends of the ribs were not abnormal. The upper and lower extremities showed ten fractures, of which six were recent, and were without formation of callus; four were older, and in different stages of healing.

Syphilis and rachitis are, he says, positively excluded in this case. A microscopic examination disclosed a deficient calcification of the bone tissue, so the author thinks that the pronounced changes which were present in this case are to be referred to an unknown intra-uterine disease of the bones, with at times softness and fragility of the bone substance. In this softened condition of the bones pressure upon the parts of the child or some movement of its own are, in the author's opinion, the immediate causes of the fractures.

Abortive Cervical Hypertrophic Pachymeningitis.

In a communication to the *Deutsche med. Wochenschrift*, No. 26, 1887, E. Remak states that in a boy 13 years old, motor disturbances of both hands suddenly occurred. There existed bilateral *main-en-griffe:* the proximal phalanges were in a position of hyperextension, the distal bent, the fingers, in a position of dorsal flexion (*main-en-prédicateur*, of Charcot). The median and ulnar nerves in the upper and forearm reacted normally to the electric current, but their palmar extensions reacted badly. The direct muscular excitability was diminished. Besides these symptoms, there were reactions of degeneration, and subjective and objective disturbances in sensibility on the part of the hands. There existed, therefore, a degenerative atrophic paresis of both upper extremities. In addition, a slight spastic paresis of the lower extremities could be demonstrated. Iodide of potash and treatment with the galvanic current brought about nearly complete recovery within two months. The neighborhood of the first to the third thoracic vertebræ was very sensitive. In view of the favorable course of the case, Remak excludes a tumor as the cause, and thinks that the trouble consisted in mild grade of cervical pachymeningitis.—*Centralblatt f. d. med. Wissensch.*, January 14, 1888.

Resorcin in the Local Treatment of Acne.

At a meeting of the Medical Society of the County of New York, Dr. G. H. Fox read a paper on this subject. There were many drugs, he said, used in the local treatment of acne, but he would confine his remarks to the one which in his hands had afforded the best results. It should be stated at the outset that there were very few cases of acne in which local treatment alone would effect a cure. In certain cases ordinary stimulating local treatment was worse than useless. From a therapeutic standpoint all cases of acne might be divided into two varieties, the indolent and the irritable. In the indolent variety, which included about half the cases, there was a doughy, thick skin covered with projecting comedones, papules and pustules. One could in these cases press out the contents of the distended glands without doing any injury to the skin. These were the cases which were benefitted by local treatment. On the other hand, there was perhaps an equal number of cases in which the glands were normal, the lesions being chiefly of a vascular character, with a few red blotches scattered over the face, and a marked tendency of the face to flush after eating and excitement. There were a few comedones, and any attempt to press them out would make the face look a great deal worse. The skin was thin and sensitive. In this class of cases local treatment would not effect a cure, and was apt to make the condition worse; we had to depend upon tonic and hygienic measures. But in the indolent class of cases, in which there was little acute inflammation of the skin, we could use some strong stimulating local treatment to advantage. The sulphur and mercurial ointments and lotions did a certain amount of good, but he thought the treatment with green soap infinitely superior. The chrysarobin treatment, as suggested by Dr. Metcalf, was certainly efficacious, but in his opinion the objections to it more than counterbalanced the objections to the disease. Resorcin he had found equally curative and free from the objectionable qualities of chrysarobin. Resorcin could be applied as a lotion or as an ointment. It caused a low grade of inflammation. Like carbolic acid, it was a mild caustic. Its application was followed by death and exfoliation of the thick epidermis, leaving a thin, healthy skin.—*N. Y. Med. Journal*, March 10, 1888.

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CHARLES W. DULLES, M. D., EDITOR.

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CASTRATION AS A CURE FOR CRIME.

In a paper read before the Cincinnati Academy of Medicine, February 27, 1888, DR. ORPHEUS EVERTS discusses with much force the advisability of what he calls "Asexualization as a Penalty for Crime." From this paper it appears that by this he means the removal of the testicles or ovaries of criminals convicted of offences recognized as likely to be repeated by their offspring. The proposition, in this country, to castrate men convicted of rape is credited to Prof. Agnew, of Philadelphia; but, as Dr. Everts states, the idea is not unlike that said to have been put in practice upon the priest Abelard for having seduced the famous Heloise. This, however, was an act of vengeance, and very different from such an act of judicial protection to society as is contemplated by those who favor castration as a punishment for rape. For in this case the object is not merely to punish the offender and to deter others from imitating his misdeed, but also to prevent him from repeating a crime of which he has shown himself capable. We doubt that it is generally intended, by those who favor it, to be a means of preventing the propagation of men with a predilection for rape.

But Dr. Everts goes much further, and boldly proposes castration as a remedy for crime in general, because it will hinder the begetting or conception of children to inherit the vicious inclinations of their parents. This is, indeed, a heroic proposition; and, while it has much to recommend it to the good opinion of thoughtful men, we cannot think that the time is ripe for its adoption. The argument in its favor by Dr. Everts is strong and deserving of careful consideration; but we think that he overlooks a very important point in the matter. This is that it would be almost, if not quite, impossible to apply the penalty of castration in a way which would commend its use to prudent men.

If it were proposed only for rape and murder, the difficulty would not be so great; because after conviction by due process of law and the lapse of a reasonable time, the infliction of castration would not appear to be a cruel or inhuman punishment. But, in any case, there would be the possibility of an unjust infliction of a very severe and irreparable injury, and—in the case of rape—of driving one who had committed one crime to the commission of another by way of retaliation. For other crimes than rape or murder, we do not believe the community would ever consent to the penalty of castration; because the determination of the individuals to which it was applicable would of necessity rest with medical men, to whom the courts have no disposition to commit their judicial functions. We cannot imagine, and would not advocate, the substitution of any board of medical experts for the organization now provided by law for the determination of the gravity of offenses against the persons or property of the citizens of the United States; and we cannot see how the penalty of castration could be inflicted for any crimes except rape or murder, without the intervention of a set of experts in psychology for whom there is no public desire, and in whom there would be no universal confidence. For this reason we regard the

proposition of Dr. Everts as chimerical, although we think that much might be said in its favor if it were restricted to the two crimes we have mentioned. For rape, we believe castration would be a fit penalty, and we would hope it might prove an efficient one; for murder, it might be adequate, although we have our doubts about this. We do not think it would be an improper penalty for either offense; and would not regret to see its merits tested for awhile at least.

BACTERIOLOGY.

There is a feeling on the part of a certain number of conservative medical men that what is generally known as bacteriology, or the germ-theory of disease, is just now being pushed a little too vigorously by its advocates. We have some sympathy with this feeling, and do not hesitate to say that—like most comparatively new theories—this one has led to exaggerations and even to serious scientific mistakes. But on the other hand we think that a fair respect for gradually accummulating evidence compels the admission that the study of bacteriology has passed beyond the tentative stage, and that it now rests upon a secure and perfectly reasonable basis. This being the case, it is a mistake to scoff at it, or to pass it by with one's ears stopped. It may be that it has unwise and too enthusiastic supporters; but it cannot be denied that it also counts among its supporters a large number of the most earnest, most intelligent and most conscientious students of medical science. It is a factor of the utmost importance in this science at the present time, and ought to be fairly considered by all who are not governed solely by prejudice.

For this reason, it is with some regret that we note the fact that a recent investigation by *Science* demonstrates that a considerable number of medical schools in the United States treat the study of bacteriology with neglect, and some of them even with scorn. Our own position of reserve in regard to certain claims of the bacteriologists makes it fitting that we should ask for them more unprejudiced treatment than they sometimes receive, and that we should call the attention of our readers to the fact that there will be no better way to restrain actual excesses of belief than to coöperate with those whose faith is more unquestioning, in the endeavor to determine the true limits and possibilities of this fascinating study. No good end can be served by simply denying what they assert, and much good may be lost by standing still and saying that it will not amount to much after all. The indications are that before long those who refuse to believe what is reasonable about germs, and the germ-theory, will be either left behind or overwhelmed by the advance of medical science; and we believe that no medical school can afford—for its own sake, or for the sake of science—to neglect the study of bacteriology. Such study may confirm, or it may refute the claims of the so-called bacteriologists; but it is a necessity of the time, and absolutely indispensable to a correct decision as to the exact position to be accorded to this vigorous progeny of modern methods of medical study.

DANGERS OF WATER-GAS.

The College of Physicians of Philadelphia has again exercised one of the most important functions for which it was originally established, and which it so recently exercised in connection with the subject of cholera and National Quarantine Regulations. A proposition being entertained by the municipal authorities of Philadelphia to introduce water-gas for lighting purposes, the College of Physicians appointed a Commission to investigate the scientific and sanitary features of the subject, and on its recommendation has addressed a communication to the Mayor of Philadelphia, in which the dangerous nature of this gas is described, and certain precautions to be used in its distribution and consumption are suggested.

The recommendations of the College of Physicians are entitled to the highest respect, and there can be no doubt, after reading the findings of its Commission, that water-gas is a dangerous compound, and one not to be used except with great care. It may be that the manufacturers of this gas can suggest a way in which its dangers can be avoided, so

that its comparative cheapness may be utilized. Until this is done, however, ordinary prudence would seem to dictate that some other kind of illuminant be chosen for use.

A TRIBULATION OF THE PRACTICE OF DENTISTRY.

In a recent number of the REPORTER we spoke of the appreciation usually enjoyed by medical men in this country, and it is with some regret that we note that so much cannot be said about our brethren of the dental persuasion. It is reported that a dentist of Jersey City has been sued for damages by a woman who grounded her action upon the allegation that he supplied her with a set of false teeth of such poor quality and workmanship that mastication is impossible, and that her digestion has thereby been ruined.

It is painful to reflect upon the unwillingness which dentists will feel to exercise the cosmetic functions of their calling, if this woman wins her suit. To expect a dentist to insure perennial strength of digestion with every set of false teeth, is asking a little too much. It might happen that a woman whose natural teeth were so poor that she would choose rather to have them—or their wrecks—extracted, and to rely upon such substitutes as human skill can construct, would have an inherent tendency to disorders of other portions of her alimentary apparatus, and then the luckless dentist might be blamed because he did not furnish a sound stomach with each set of masticators. It might happen, we say; because medical men have conceived the possibility that miserable teeth may be anything but the outward and visible sign of an inward and spiritual grace.

This being the case, we trust the community may not get into the way of thinking that dentists can supply all the defects imposed by a relentless Providence, or acquired by careless or ignorant human beings. We have no desire to come between an unworthy man and a justly incensed woman, but, as the courts are said to exist for the especial protection of the weak, we trust that when any unfortunate man—dentist or doctor—is charged with malpractice he may not be convicted because any very simple dictate of common sense has been overlooked in judging his apparent delinquency.

MEDICAL "ENGLISH AS SHE IS WROTE."

In a report of the French Congress or Surgeons in Paris, received by the REPORTER within a few days, there are many amusing passages, among which are the following: M. Thiriar, is made to say, of the operation of resection of the ribs: "After having tried all the processes, I am now making my costal amputation by means of a single transversal incision. I can easily take away seven or eight ribs, and I usually obtain a joint at the first attempt."

M. Delorme, is reported as speaking of certain defects of the operation, and adding "But it would be quite otherwise if to the osseous resection were added the vertical section of the inner side in the whole height of the cavity and a compress made of the carneous shreds to bring them into contact with the opposite inner side. If the cavity were extended even beyond the limits of resection, the lateral orifices could be obliterated, and if necessary the inner side compressed and fixed in this position with catgut."

M. Lannelongue is credited with the startling announcement that as early as the 31st of May, 1887, he had "pointed out the multifarious origins of sub-phrenic or epi-hepatic abscesses, and recommended according to their location, either by the simple opening of the inner side of the belly, or the resection of the abdominal portion of the thorax, including the lower edge."

These examples of "English as she is wrote" are too delicious to be allowed to pass into oblivion, and deserve to be placed on record together with those others in ordinary English which have of late afforded so much amusement to American readers. They do not disclose peculiar ignorance on the part of the French writer, but rather the pit-falls which lie in the way of one who makes a venture in a foreign tongue, with that treacherous guide—the dictionary. The errors are not only very interesting in themselves, but also on account of the philological questions which they suggest, and it will afford not

only amusement, but instruction as well, to trace the way in which some of the most striking and ludicrous of them have crept into this report.

FORCIBLE FEEDING OF THE INSANE.

In an editorial of the REPORTER, March 10, 1888, we called attention to a recent paper by Rader upon the subject of forcible feeding of the insane. In this editorial we spoke with approval of the views expressed by Rader, and pointed out some of the apparent dangers of this method, as well as the fact that it might be resorted to when it was by no means necessary.

Our editorial attracted the attention of the Philadelphia Neurological Society, and it took the subject up for discussion at its meeting, March 26, 1888. In this number we publish in full so much of the proceedings of that meeting as refer to the forcible feeding of the insane. From the report which we give, it will be seen that the general sentiment of those who spoke was that the dangers of forcible feeding of the insane are not so real or so great as to counterbalance its advantages. This is not exactly the view expressed in our editorial; but it is one entitled to the greatest respect. Certainly when a number of men who have made insanity a special study declare plainly in favor of what a single expert deprecates, the presumption is that they are right; and the REPORTER, under the circumstances, may adopt the language of Sir Thomas Browne in regard to his Religio Medici, of which he says: "Lastly, all that is contained therein is in submission unto maturer discernments; and, as I have declared, shall no further father them than the best and learned judgments shall authorize them."

NEW USE FOR A STATE BOARD OF HEALTH.

In one of the passenger railway lines of Philadelphia we have observed an advertising sign which states that "The Pennsylvania State Board of Health gives the highest endorsement for purity to Germania bottled beer." We think there must be some mistake about this.

BOOK REVIEWS.

[Any book reviewed in these columns may be obtained, upon receipt of price, from the office of the REPORTER.]

UEBER DIE LEPRA IN DEN OSTSEE-PROVINZEN (ON LEPROSY IN THE BALTIC PROVINCES). I. FLUGBLATT. 8vo, pp. 16. Dorpat, 1887. Printed by K. A. Hermann.

This little brochure has been prepared by Prof. von Wahl, of Dorpat, as a means of furnishing information to the proper persons in Russia in regard to the subject of leprosy, and in order to stimulate co-operation in the work of gathering further information. One of the most important points discussed is that of the infectious and contagious nature of leprosy. This is thoroughly believed in by Prof. von Wahl, who thinks, however, that the disease is contagious only when the lepra-bacillus is liberated from the body which bears it by an ulcerative process. His paper is illustrated with three beautiful photographs, showing one patient with tuberculous leprosy, and two with macular or anæsthetic leprosy.

EIN STUDIE ÜBER DIE LEPRA IN DEN OSTSEEPROVINZEN, MIT BESONDERER BERÜCKSICHTIGUNG IHRER VERBREITUNG UND AETIOLOGIE. Von PETER HELLAT, Inaugural Dissertation. 8vo, pp. 103. Dorpat: K. A. Hermann's Buch-und Noten-Druckerei, 1887.

This interesting thesis, which contains a map and two engravings of microscopic sections of the skin in a case of leprosy, was prepared under the supervision of Prof. von Wahl, who has taken a great interest in the subject. Dr. Hellat's monograph is one which is calculated to be of great service to all students of leprosy, and especially to those who are interested in its history and developments in the Baltic provinces of Russia. It contains a very thorough study of the subject, and the illustrations contribute very materially to its worth.

THIRD ANNUAL REPORT OF THE MANAGERS AND SUPERINTENDENT OF THE NORTH TEXAS HOSPITAL FOR THE INSANE, AT FERRELL, FOR THE YEAR ENDING OCTOBER 31, 1887. Austin: State Printing Office. 26 pages.

The report of the North Texas Hospital for the Insane, it is interesting to note, does not call the institution an "insane hospital." In keeping with this example of correct expression, we find the contents of the report marked by many evidences of good sense. This one contains, among other things, an account of the findings of a number of autopsies—which, the report states, are made in all cases in which the bodies are not claimed for burial—and an account of the efforts made to secure a good library for the inmates of the hospital. On the whole, the managers and superintendent are to be congratulated on the evidence furnished by their report that the hospital under their care is governed according to the best principles of humanity and science.

PAPERS READ BEFORE THE LANCASTER CITY AND COUNTY MEDICAL SOCIETY, AUGUST, 1885—MARCH, 1888. 8vo, paper, pp. 55. Printed by the Society.

It was a good idea for the Lancaster Medical Society to gather into one volume eight of the papers

read before it during the last three years; and the friends of the Society will share the pleasure with which it must regard the products of the brain of its members. One of the most interesting essays in the book before us is that of Dr. John T. Carpenter, who, under the title "Some Things that I have Learned in Medicine," gives an entertaining and Instructive account of the changes which have taken place in medical thought during his lifetime. In addition to this, there are here three reports on surgery by Dr. Alex. Craig and Dr. S. B. Foreman, a paper on Salicylic Acid in the Treatment of Rheumatism, by Dr. J. H. Musser, now of Philadelphia, but a Lancaster county man by birth; a paper on Preventive Medicine, by Dr. D. B. Weaver; a Report on the Practice of Medicine, by Dr. A. M. Miller; a Report on Obstetrics, by Dr. M. W. Hurst and Dr. J. H. Musser; a paper on Two Interesting Cases of Eye Disease, by Dr. D. B. Weaver; and one on Ileo-Colitis, by Dr. G. W. Berntheizel. The whole is very interesting reading and very creditable to the Society from which it emanates.

TRANSACTIONS OF THE HOMŒOPATHIC MEDICAL SOCIETY OF THE STATE OF NEW YORK FOR THE YEAR 1887. 8vo, paper, pp. 132. Rochester, N. Y.: published by the Society, 1887.

The most striking feature of this volume of transactions is the fact that it is very hard to find any homœopathy in it. A large number of the papers are upon surgical and obstetrical subjects, and several of them are upon the treatment of insanity. In one of the latter, Dr. David A. Gorton describes a case of melancholia which he treated with mercury in doses of a quarter of a grain every four hours for three days; and this good old-school dosage called forth no protest. It is a pity that so much that is excellent as is displayed in this volume should not have found a place under the flag of the regular school of medicine, where it rightfully belongs, instead of under that of homœopathy, which has no claim upon it whatever.

Pamphlet Notices.

[Any Reader of the Reporter who desires a copy of a pamphlet noticed in these columns will doubtless secure it by addressing the author with a request *stating where the notice was seen* and enclosing a postage stamp.]

THE MEDICAL JURISPRUDENCE OF INEBRIETY. By JOSEPH PARRISH, M.D., Burlington, N. J. From the *Journal of Inebriety*, January, 1888. 7 pp.

AN ADDRESS DELIVERED BEFORE THE CORPORATION OF THE WASHINGTONIAN HOME, BOSTON, MASS., ON ITS THIRTIETH ANNIVERSARY, FEBRUARY 20, 1888. By T. D. CROTHERS, M.D., of Hartford, Conn. 18 pp.

BIOGRAPHICAL SKETCH OF DR. AUSTIN FLINT. By J. M. DA COSTA, M.D., LL.D. From the *Transactions of the College of Physicians of Philadelphia*. Third Series Volume IX. 10 pp.

L'ANTIPYRINE: SON ACTION SUR LA NUTRITION; SES INDICATIONS GÉNÉRALES. PAR ALBERT ROBIN, Membre de l'Académie de Médecine, etc. From the *Bulletin de l'Académie de Médecine*, December 6, 1887. 27 pages.

TRAITEMENT DES FIÈVRES ET DES ÉTATS TYPHOIDES PAR LA MÉTHODE OXYDANTE ET ÉLIMINATRICE. PAR ALBERT ROBIN, Membre de l'Académie de Médecine, etc. From the *Archives Générales de Médecine*, January, 1888. 38 pp.

—Dr. Parrish's pamphlet contains a brief but earnest argument in support of the theory that inebriety is often a manifestation of mental disease, and not of moral infirmity. He uses the inexact expression, "Inebriety the Disease," which is partly responsible for the misunderstanding of the position held by those who share his views, on the part of those who think they are both erroneous and harmful. Men like Dr. Parrish, who have made a special study of the phenomena of intemperance in the use of alcoholic stimulants, ought to know more about it than those to whom it is but an occasional object of study; and—without admitting the soundness of their opinions when pushed to the extremes to which they are sometimes pushed—it must be acknowledged that there is a great deal of force in what they say, and that it deserves at least respectful consideration.

—Dr. Crothers' address gives a very interesting and ably written history of the Washingtonian Home, and incidentally of certain features of the temperance movements in this country since 1859. In addition to this, it contains a very good summary of the steps by which the study of inebriety has come to be so largely one of mental disorders. Dr. Crothers goes back to the ancient records of Egypt and Greece to show that, long before the Christian era, the abuse of alcoholic stimulants was regarded as an evidence of bodily and mental disease, and traces the progress of this opinion in America from the time when, in 1790, Dr. Benjamin Rush, of Philadelphia, discussed it, until the present day. Incidentally, he also makes a plea for a more general acceptance of this opinion, which he believes furnishes the only scientific basis for curing the evils of intemperance.

—Dr. Da Costa's sketch of the life of Dr. Austin Flint is a graceful and elegant tribute to the memory of one of the most eminent medical men and medical teachers of this century. Its brevity is not the least of its merits, and it furnishes an example worth imitating of the way in which a tempting subject may be handled without diffuseness or prolixity.

—Prof. Robin's paper on antipyrine contains the most complete and scientific discussion of the physiological effects of this drug which we have seen. The results of his labors, the full details of which are given here, indicate that antipyrine is to be considered rather as a nervine than as a drug to be used to reduce temperature; and that its best effects are to be expected when it is administered to control nervous excitation and to diminish pain. On the other hand, Prof. Robin shows that antipyrine diminishes the process of oxidation in disintegrated tissues, and ought not to be used in the treatment of diseases in which this process is to be favored. Finally, he describes the antiseptic properties of antipyrine, even when administered in small doses. The whole paper is one of extreme interest and value, not only for what it teaches in regard to the uses of this particular drug, but also as an example of the way in which the effects of any drug may be profitably studied.

—We have already, in an Editorial in the Reporter, February, 25, 1888, called attention to the principles laid down in this admirable paper of Prof. Robin as those which ought to guide the practitioner in the treatment of fevers and typhoid conditions.

As we then stated, he believes, and we think demonstrates, that fevers, and especially typhoid fevers, are to be treated by some method which facilitates or promotes the process of oxidation in the tissues, and of the elimination of the products of retrograde metamorphosis. The argument of Prof. Robin is founded upon careful chemical analysis and clinical observation, and may be strongly recommended to the attention of medical men, and especially of medical teachers.

Notes and Comments.

Contribution to the Etiology of Congenital Syphilis.

In addition to the intrinsic importance of the subject, the question of congenital or hereditary syphilis is one that possesses great interest to the student, because of the many uncertainties connected with it. Syphilographers are now very generally agreed that a syphilitic woman may beget a syphilitic child without infecting her husband, and some believe that a man who is a sufferer from the disease in its later stages may beget a syphilitic child while the mother escapes infection. Although there is little doubt concerning the first of these points, there is, nevertheless, much dispute as to the time at which the child becomes infected. It was formerly held that a woman who did not acquire the disease before the seventh month of gestation would give birth to a healthy child. Chabalier has reported a case in which a woman became infected sixty-three days before the birth of a syphilitic child. But an instance is now related by Dr. F. Sorrentino, in *La Riforma Medica* of December 23, 1887, in which the date of infection was but fifty-two days before delivery.

A woman, 26 years of age, of sound general health, had been married at the age of 20 to a coffee-house keeper, by whom she had had two healthy children born at term. In May, 1886, her husband left her, when she was two months pregnant, and went to Marseilles on business. He returned home on November 14, and had intercourse with his wife at that time, infecting her with a syphilis which he had contracted during his absence. Fifteen days after the primary sore was noticed an extensive roseola appeared, which was treated energetically by subcutaneous injections of mercuric chloride. The child was born on January 5, fifty-two days after the mother's infection. It seemed at first to be healthy, but soon manifested the symptoms of hereditary syphilis. There was no sore about the lips, mouth, or pharynx to suggest the possibility of infection from the mother post-partum.

This case, if all sources of error can be excluded, would appear to demonstrate conclusively that a woman may give birth to a syphilitic child when her disease is contracted later than the seventh month of gestation.—*Medical Record*, March 22, 1888.

A Perfect Insect Powder.

Under the name *Poudre insecticide perfectionnée* a new and very efficacious insect powder has been introduced into the European drug trade. It consists simply of pyrethrum flowers to every 100 parts of which by weight, 1 part of naphthalin has been added. The naphthalin must be in very fine powder and intimately mixed with the pyrethrum. As a great deal of insect powder (in bulk) now found in the market is scarcely worthy of the name, we would suggest that our readers may avail themselves of the information here given, and convert such stock, if they chance to have any of it on hand, into a valuable and rapidly-selling article. A specimen of a powder sold by an itinerant vender to a restaurant-keeper in this city a short time ago, and found to be very efficacious against roaches especially, was on examination by the writer found to consist of pyrethrum mixed with borax in exceedingly fine powder. Borax alone is an excellent blatticide.—*National Druggist*, March, 1888.

Antipyrin as a Hæmostatic.

Dr. W. M. Powell, in a communication to *Daniel's Texas Medical Journal*, March, 1888, says that he was sent for in haste to see a woman who had a frightful hemorrhage from a sore leg which had been struck, and when he arrived he found her nearly exhausted. A four per cent. solution of antipyrin was applied, and he had the satisfaction of seeing the bleeding quickly checked. A light compress and bandage was then applied, and the extremities elevated on pillows in bed. No more hemorrhage occurred.

A few days later he operated on a boy seven years old for phimosis, removing nearly one inch of the prepuce; the hemorrhage was profuse. Before removing the clamp forceps he applied a four per cent. solution of antipyrin, and also immediately after removing them. All bleeding was promptly arrested and mucous membrane and foreskin were neatly brought together with numerous stitches without the least annoyance from further hemorrhage. A simple water dressing completed the operation, and on redressing, the following day, he says he does not think he ever saw a cleaner, nicer wound.

Jaborandi in Hiccough.

In a case of obstinate hiccough which continued day and night and brought the patient fearfully low, all possible means—bromide of potash, morphine, belladonna, galvanism, pressure upon the trunk of the vagus and phrenic—were employed without relief. Küthe, however, secured prompt success from a decoction of jaborandi, 8 parts to 180. The hiccough did not recur.—*Nederlandische Tijdschrift voor Geneeskunde.*

Antifebrin in Hemicrania.

Ott (*Prager med. Wochenschrift*, No. 47, 1887), has found that antifebrin exerts an extremely prompt action in hemicrania, even in obstinate and old cases. He gives seven and one-half grains at the beginning of the attack. The result is said to be admirable. The drug also did good service in a woman suffering from trigeminal and occipital neuralgia, with dysmenorrhœa.

Human Electricity.

A hemi-anæsthetic, hysterical woman, says the *Lancet*, February 11, 1888, was shown at a recent meeting of the Société de Biologie, from whom M. Féré could, under certain circumstances, disengage at the surface of the body luminous tufts, one-sixth of an inch long. The son of this woman, likewise hysterical, presented the same peculiarity. In both the skin was remarkably dry. These phenomena could be easily augmented by provoking sensorial excitations. Such phenomena are known more commonly in certain hot and dry tropical climates.

Injections of Quinine in Gonorrhœa and Cystitis.

Dr. Frank L. James says that after reading in the *Indian Medical Gazette*, a number of years ago, a clinical note by a native surgeon in the British East Indian Service on injections of quinine in the early treatment of gonorrhœa, he tried the formula there recommended. He found it extremely painful, the quinine being dissolved in an acid mixture. He then tried the following formula:

℞ Quininæ sulphatis.....ʒss
Morphinæ sulphatis.....gr. viii
Mucilaginis acaciæ.....fʒiss
Aquæ q. s. ad.....fʒviii
M. Fiat mistura.

He found this "cooling and soothing" when injected into the urethra in quantities of half an ounce. The first patient upon whom it was tried got well with great rapidity. Since that time he has used the remedy many hundred times and while sometimes duplicating his first success, and sometimes failing utterly with it, he says that in about sixty (60) per cent. of all the cases in which it was faithfully used in the earlier stages of the disease, it brought about a rapid and almost painless recovery. Subsequent experience has taught him that when used in the latter stages it was rarely of any service.

He also states that the results of intravesical injections by gravity have been very gratifying both in acute and chronic cystitis, in old gleets and even in prostatic troubles.

In the treatment of acute blenorrhœas with the quinine mixture, he usually advises the patient to inject a half syringeful before urinating, and if there be much ardor urinæ to immerse the parts in water as hot as he can bear it; to urinate in the hot water, and after urination again to inject the quinine mixture. For chordee he says he finds nothing to equal veratrum viride, twenty minims of the tincture to be taken on retiring.—*St. Louis Med. and Surg. Journal*, April, 1888.

Paraldehyde Mixture.

Schmitt recommends (*Rundschau, Prag.*) the following very expeditious way of making a mixture of this substance: 20 parts of paraldehyde are vigorously shaken in a bottle with 30 parts of syrup and 60 parts of mucilage, and then at once 90 parts of water are added, shaking again. If the quantity of water does not greatly exceed 90 parts, the paraldehyde will remain suspended.—*Druggists Circular*, April, 1888.

Creasote in Phthisis.

Dr. Peter Kaatzer, of Rehburg, strongly recommends, in the *Berliner klinische Wochenschrift*, March 12, 1888, the administration of creasote in the treatment of phthisis. After trying various formulæ he has settled upon the following as the best:

℞ Creasoti purissimi.....2 parts
Alcoholis.....30 "
Tr. gentianæ,
Ext. caffeæ.....āā..10 "
Aquæ destillatæ.....100"
M. Sig.—Shake well and take a tablespoonful in half a glass of milk twice daily.

Cocaine in Dilatation of the Cervix for Dismenorrhœa.

Dr. M. F. Birdsong, in a communication to *Daniel's Texas Medical Journal*, March, 1888, says that in a young married woman, 20 years old, who had menstruated first when

13 years old, he had occasion to dilate the cervix for painful menstruation. The cervix was long and slender, with pinhole os; nothing else abnormal was discovered. As she was opposed to taking chloroform, he proposed to use cocaine as a substitute, to which she consented. He used the following solution:

Cocaine hydrochlorate.....gr. x.
Water.....℥ x.
Liquid vaseline.....f ℥ iv.
M.

Two slender whale-bone probangs were wrapped with absorbent cotton, and the cotton saturated with the solution. One of them was introduced fully into the uterus and left *in situ*. Absorbent cotton was saturated with the solution and packed around the vaginal portion of the cervix and allowed to remain for fifteen minutes, when it was all removed and another application, as above, was used, and allowed to remain the same time, when it also was removed. The dilator was then introduced and dilatation began at once, and in a few seconds it was over. For fear he had not fully dilated the internal os, he closed the instrument and pressed it in farther, and dilated again. All of this was done with but little pain to the patient. In about ten days she menstruated with but little pain, not more than is common for women, and is now pregnant and in fine health. A second case, in which lanoline was used for vaseline, with equally successful result, is also mentioned.

For Burns.

The following formula, says the *Deutsche med. Wochenschrift*, March 15, 1888, is recommended by Nicot, Vuillet, and other French authors:

Salol.....grs. 37½
Lime water,
Olive oil, of each.....drachms 2½
Mix. Use as an ointment to the affected parts.

Irido-Choroiditis from Exposure to Sunlight.

It appears that Professor Plateau, of the University of Ghent, while trying to observe the effects of the irritation of the retina gazed steadily at the sun for twenty seconds, the result being that chronic irido-choroiditis developed, ending eventually in total blindness. A number of cases are known in which choroiditis and retinitis occurred in persons who had observed an eclipse of the sun. The single flash of a sun reflector has been known to cause retinitis, and other temporary visual disturbances of a functional character have been frequently noted.—*Public Opinion*, March 24, 1888.

Water from the Sea for English Towns.

The scarcity of water in many large towns in Great Britain is causing much alarm. The city of Liverpool, and the sister city, Manchester, are in great danger of a water famine, the former having only about ten days' supply in the reservoirs. A proposal to bring sea water in mains from the coast to the large inland towns of England has been made by Mr. Ellis Lever, of Manchester, and has been received with much favor by the press and public. Mr. Lever's proposition is to lay pipes for sea water, side by side with the fresh-water supply, and that the sea water should be used for baths, closets, watering streets, flushing sewers, and in extinguishing fires. For all this, and many other purposes, sea water is more efficient than fresh water. The object Mr. Lever has in view is to economize the fresh-water supply. The question is forcing itself upon the attention of the British Parliament, and a proposal is being made to appoint a royal commission to inquire into the water-supply of Great Britain. The King of the Belgians is also alive to the importance of this subject, and has offered a prize of 25,000 francs for the best treatise on the water-supply of large towns.—*N. Y. Evening Post*, April 4, 1888.

Appointments at St. Agnes's Hospital.

The new Hospital of St. Agnes in Philadelphia, is to be formally dedicated during the latter part of the present month, and patients will be received early in May.

The following is the staff of physicians and surgeons:

Medical Director, Dr. J. H. Grove, A.M., M.D., LL.D.

Medical Staff, Professor Horatio C. Wood, M.D., LL.D.; Professor James Tyson, Dr. John M. Keating and Dr. Michael O'Hara.

Surgical Staff, Professor W. W. Keen, Professor J. Ewing Mears, Professor John B. Roberts and Dr. Joseph M. Fox.

Medical Out - patient Department, Dr. George Dock and Dr. Hobart A. Hare.

Surgical Out-patient Department, Dr. J. F. Walsh and Dr. Charles B. Penrose.

Ophthalmologists, Dr. Charles A. Oliver and Dr. Francis M. Perkins.

Dispensary for Throat, Nose and Ear, Dr George Y. McCracken and Dr. John Sheets

Gynecologist, Dr. D. W. Cadwallader.

Dispensary for Diseases of Children, Dr. Robert Kilduff.

Pathologist, Dr. Andrew J. Downs.

Jefferson Medical College Prizes.

At the sixty-third annual commencement of the Jefferson Medical College of Philadelphia, April 4, 1888, prizes were awarded as follows:

1. A prize of $100 by the *Medical News*, for the best Thesis, to Laurence Reynold Ryan, of Illinois, with honorable mention of the thesis of George M. Gould, of Massachusetts.

2. A gold medal, for the best essay on a subject pertaining to the practice of medicine, to Augustus A. Eshner, of Pennsylvania, with honorable mention of the essays of William Louis Baum, of Illinois, and William L. Whittington, of Missouri.

3. A gold medal, for the best anatomical preparation, to William M. Browder, of Alabama, with honorable mention of the preparation of John W. Groff, of Pennsylvania.

4. A gold medal, for the best work in chemical laboratory, to John Charles Hierholzer, of Pennsylvania.

5. A case of instruments, for the best original research in the Materia Medica Laboratory, to Jacob S. Pragheimer, of Pennsylvania, with honorable mention of the essay of Samuel Tevis, of California.

6. A gold medal, for the best essay on a subject pertaining to physiology, to John J. McFadden, of Pennsylvania.

7. A case of instruments, for the best essay on a subject pertaining to surgery, to Edward L. Beal, of Missouri.

8. A gold medal, for the best essay on a subject pertaining to obstetrics, to Sylvester S. Kring, of Pennsylvania, with honorable mention of the essay of J. Howard Frick, of Pennsylvania.

9. A case of instruments, for the best essay on a pathological subject, to Edgar Parker Hershey, of Pennsylvania.

10. A gold medal to William Stephen McDonald, of Maine, for the best report of Dr. Thomas G. Morton's Surgical Clinic at the Pennsylvania Hospital.

Correction.

Prof. Gross says that the class-room note on the "Preservation of Ligatures," (REPORTER, March 10, p. 318), taken from the *College and Clinical Record*, should have been "Preservation of *Sutures*," the formula being Macewen's. He also says there should be no carbolic acid in the solution used to preserve them (alcohol, parts 15, glycerine, part 1).

NEWS.

—Dr. Martineau, the well-known physician of Paris, died recently at the age of 52 years.

—It is announced that Dr. Oliver Wendell Holmes has given his medical books to the Boston Medical Library.

—The death of Dr. Hippolyte Blot, Secretary of the French General Association of Physicians, is announced.

—The Missouri Medical College held its annual commencement March 6. The school is in a prosperous condition.

—Dr. Robert Travers, Professor of Medical Jurisprudence in the University of Dublin, died March 27. He was appointed Professor in 1864.

—It is customary in the election of a President of the Royal College of Physicians of England to give, after the election, to each Fellow present, a new half-crown. The origin of the custom is not known.

—The Philadelphia College of Pharmacy at its 67th annual commencement held recently graduated 137 as pharmacists, including one young lady. This is the largest class the school has ever graduated.

—An Indiana doctor is said to have begun marrying in 1832, and now at the age of seventy-five to have just married his seventh wife. None of the seven was over thirty-one years old when she became the doctor's wife.

—The *Ledger*, March 16, 1888, says: A real live British peer in America is John Contee Fairfax, M. D., of Northampton, Maryland. According to "Debrett's Peerage" he is the eleventh Baron Fairfax, and last year he received from the Queen a formal invitation to be present with his fellow-peers at her Jubilee in Westminster Abbey. This invitation he did not accept. He has now retired from the active practice of his profession, and lives a quiet, simple life on his farm. The dowager Baroness Fairfax, widow of the tenth Baron, is living on a ranch in California. Numerous uncles, aunts, and cousins of Lord Fairfax are living in this country. Many of them took part in the Rebellion, but one of them became a Commodore in the United States Navy. It was Thomas, the sixth Baron Fairfax, who settled the family in this country. They are all descended from the famous Fernandino, second Baron, who led the revolutionary forces and defeated the King at Marston Moor; and from his son Thomas, third Baron, who commanded the cavalry at Marston Moor and was in chief command at Naseby.

HUMOR.

In the chemical laboratory: Professor—What has become of Tom Appleton? Wasn't he studying with the class last year?"

"Ah, yes; Appleton—poor fellow! A fine student, but absent-minded in the use of chemicals—very. That discoloration on the ceiling. Notice it?"

"Yes."

"That's Appleton."—*Tid-Bits.*

A young preacher the other day, undertaking to "stump" Bishop Foss, of the Methodist Church, with a "temperance" question, said: "Why, brother, if there was a mad dog running up and down the streets, would you shoot it or would you hedge it in?" To which the wise bishop made quick reply: "If that mad dog had been running up and down the streets for 30 years, and I had been blazing away at it all that time without hitting it, I guess I'd try and hedge it in."—*Chicago Advance.*

"That farm scene you seem to be sneering at, sir," said the indignant artist, "is valued at $500. It is generally considered a fine painting. Allow me to ask you if you are familiar with works of art?" "Not very familiar," replied the agriculturist, who was looking through the studio with his wife, "but I know something about the works of nature, young man; and when you make a cow that gets up from the ground by putting out her fore feet first you are doing something that nature never did."

The Secretary of the Health Department of Baltimore receives many curious certificates from physicians of that city. From a number recently sent in the following "causes of death" are worthy of note: A report on the death of a lady, eighty-five years of age, reads: "Cause of death, fall from third-story window. Seeing it was a fatal case I let her die in peace, which she did in one hour and twenty minutes." Another certificate makes the sad announcement: "A boy four years old died from eating a heavy piece of apple-pie four hours before death."

An English Gentleman found a large turnip in his field of the shape of a man's head, and with the resemblance of the features of a man. Struck with curiosity, he had a cast made of it, and sent the cast to a phrenologist, stating that it was taken from the head of a celebrated professor, and requested an opinion thereon. After sitting in judgment, it was reported that it denoted a man of acute mind and deep research, that he had the organ of quick perception, and also of perseverance, with another that indicated credulity.—*Kansas City Med. Record,* March, 1888.

Sausages, cooked or half raw, highly spiced, are an essential of German cookery. In order to prevent the Germans from exposing themselves to a number of bad diseases incidental to pork, the authorities insist upon the pigs being examined before being offered for sale. A peasant was arrested for evading this law, and upon being asked to to explain, said that he had a most accurate method of determining the soundness of pork. The pastor of the district was always hungry, so the peasant always sent him the first sausage made from each pig slaughtered, and a week later called to inquire after his health. If it was all right the pork went to market, and the examination fees were saved.

OBITUARIES.

S. C. THORNTON, M.D.

Dr. S. C. Thornton, died recently at his home in Moorestown, New Jersey. He was graduated from the University of Pennsylvania in 1852. His funeral on April 13, was attended by a number of the members of the Burlington County Medical Society.

Official list of changes in the Stations and Duties of Officers serving in the Medical Department, U. S. Army, from April 8, 1888, to April 14, 1888:

Capt. Geo. E. Bushnell, Assistant Surgeon, from Fort Preble, Me., to Camp Pilot Butte, Wyo.

First Lieutenant Wm. Stevenson, Assistant Surgeon, from Camp Pilot Butte, Wyo., to Fort Verde, Ariz.

First Lieutenant E. A. Mearns, Assistant Surgeon, from Fort Verde, Ariz., to Fort Snelling, Minn.

First Lieutenant Wm. L. Knudler, Assistant Surgeon, from Fort Snelling, Minn., to West Point, N. Y.

First Lieutenant W. C. Border, Assistant Surgeon, from Fort Douglas, U. T., to San Antonio, Tex.

First Lieutenant G. L. Edie, Assistant Surgeon, from San Antonio, Tex., to Fort Douglas, U. T. S. O. 79, A. G. O., April 6, 1888.

Changes in the Medical Corps of the U. S. Navy for the week ending April 14, 1888:

Passed Assistant Surgeon Henry T. Percy, from Naval Academy, and to Hospital, Washington, D. C.

Passed Assistant Surgeon M. H. Crawford, from Hospital, Washington, D. C., and wait orders.

Surgeon J. M. Flint, from Fish Commission duty, and special duty at Smithsonian Institution.

Surgeon R. C. Persons, to duty in charge of Army and Navy Hospital, Hot Springs, Ark.

Assistant Surgeon E. P. Stone, from further treatment, and to duty, Hospital, New York.

Medical Director David Kindleberger, from Hospital, Washington, D. C., and wait orders.

Medical Inspector A. A. Hoehling, to Naval Hospital, Washington, D. C.

Passed Assistant Surgeon G. E. H. Havmon, to duty Naval Academy, Annapolis, Md.

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Clinical Lecture.

PARALYSIS AGITANS; LOCOMOTOR ATAXIA; LATERAL SCLEROSIS; PARAPLEGIA.

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(Reported by William Whitford.)

Paralysis Agitans.

The patient to whom I first direct your attention is 73 years old. She has had this fine rhythmical tremor which you observe about four years. She tells us that it first began in the feet, then it made its appearance in the fingers of the left hand, and later manifested itself in the right side. This kind of tremor we call *paralysis agitans*. It closely resembles the tremor of multiple sclerosis, but you notice that it is a fine, constant, rhythmical movement, uncontrollable by the will power. Now, let us see if voluntary movement increases it or not. Sometimes in this disease it does, sometimes it does not. In this case it does not; it works with the utmost regularity—in fact as regularly as the movements of the pendulum of a clock. It is present when there is no effort at voluntary movement. The tremor of multiple sclerosis is coarser, more jerky, as it were, and it is not present, in the early history of the case, unless the patient attempts voluntary movement. The tremor of paralysis agitans, however, is present only when patients are awake; when they are asleep it ceases. The unusual feature about this case is, that the tremor began in the lower extremities. Usually it begins in one of the upper extremities, in the index finger and thumb, making what has been called the "pill movement," after which other fingers or areas of the body become involved—an arm, for instance; then it may jump to the other side, and finally reaches the lower extremities. You notice, also, in this case the tremor about the head.

The gait of paralysis agitans is peculiar. You notice the position of the body; the head is well in advance of it, during locomotion; she tumbles forward when she gets up to walk. As Trousseau says, these patients seem always to be pursuing their centre of gravity.

The pathology of paralysis agitans is shrouded in mystery. In some recent cases chronic degeneration has been found around the central canal, and in the column of Clarke of the spinal cord; also, in the cerebellum in the corpus striatum, and in the cerebral cortex.

It is a disease of old age, but every now and then it shows itself in young people. I saw a patient not long ago only thirty years of age, in whom the tremor had been manifested for three or four years. I have seen other cases under forty; but, as a rule, it is a disease which occurs in people of sixty-nine to seventy years of age.

Treatment.—Whatever the pathology of the affection may be, it is due to a depressed condition of the nervous system, and it demands for the prevention of its rapid progress judicious tonic treatment. The tremor, which is the most disagreeable feature of the disease, is controllable to a very large extent by the administration of hyoscyamus, or its alkaloid hyoscyamine. We will order for this patient one sixtieth of a grain of hyoscyamine at bedtime, and a capsule containing one-tenth of a grain of phosphide of zinc after eating, three times a day.

The subcutaneous injection of arsenic is sometimes of much service. You can take the tablets of arseniate of sodium, one-tenth

of a grain each, and give one injection daily. The ordinary Fowler's solution is very liable to produce abscess if used subcutaneously.

Do as you may you cannot cure the disease, but you may alleviate it.

Locomotor Ataxia.

Observe the peculiar locomotion of this patient; see to what extent he widens his base as he walks. You notice that he brings his heels down first; the back part of the heels of both shoes are considerably worn. He is forty-nine years of age, and was attacked with this disease four years ago. He has sensations of pins and needles, running from the elbow down to the tips of his fingers. I am pricking him severely, you notice, with a sharp-pointed pin, and he does not feel it. The tactile sense has disappeared, and there is but little appreciation of pain sense in the left hand. There is comparatively little tactile sense in the right hand; pain sense is also slight. A severe prick with a pin is slightly appreciated. He says he has darting pains all over his body; they come suddenly and disappear suddenly. Three or four days ago he said he had pain in the left foot, in a spot about half an inch square. The pains are localized, they do not follow the course of the nerve trunks. They do not often occur twice in the same place; they do not include the whole limb; a half dollar will usually cover the point of this sharp, shooting pain. Notice his eyes; they do not respond to light, and the pupils are contracted.

We will now see what the condition of the patellar-tendon reflex is. We will have him clasp his hands and attempt to pull them apart, and in this way we will do two things: (1) Increase the muscular tonus; and, (2), Divert his attention, and if there is any reflex we will find it out by tapping just below the patella. There is no response in the left nor in the right leg. It is not the absence, simply of patellar-tendon reflex that is pathological, because we now and then meet with perfectly healthy people who have no reflex, but it is the loss of it. If it was present, and is absent now, we know there is some pathological disturbance.

A physician of this city found out a few years ago that he had no patellar-tendon reflex. He therefore studied his spinal condition, and began to wonder if he had incipient locomotor ataxia. He became much alarmed about himself, and began investigating the question of patellar-tendon reflex, and it is surprising how many persons he has found in perfect health who have no such reflex. So the simple absence of it is not necessarily pathological.

Let us test his power of coördination. I will make a little spot on his forehead, and ask him to touch it with his finger. You see he does not come within three-fourths of an inch of hitting it. I will now have him stand erect with his feet close together and his eyes shut. You see he would fall if I did not support him. The loss of patellar-tendon reflex, the incoördination of muscular movement, the peculiar locomotion, makes this a case of locomotor ataxia. The numbness, the loss of tactile sense, the incoördination of muscular movement, began in the left upper extremity. The disease usually begins in the lower extremity.

He had this disease about a year before he came to Chicago. He came from the West, and while there his pains were not very severe. Neither had he any trouble with the lower extremities. The disease must have invaded the lumbar enlargement of the spinal cord when he came to this city. He tells us that he had a sensation as though he was walking on carpet or wool when he first came to Chicago.

Case II.—We will next turn our attention to the patient sitting along side of him. He is fifty-eight years of age. A year and a half ago he began having pain in the feet and in the legs, and has it now. He describes it as "sharp, shooting, and lancinating" in its character, which quickly disappears and returns, the interval between the attacks being about a minute and a half. He has this pain about once every two weeks. We will ask him to walk across the room. You notice that the gait is of the same character as in the patient who has just been examined; there is some broadening of the base as in the other case; he brings down his heels first, and the heels of his shoes are worn in the same manner. Patellar-tendon reflex is gone. I will now make a little spot with a pencil on his forehead, as we did in the other case, and ask him to touch it with the tip of his finger. You see he cannot do it. His pains commenced first in the arms, then attacked the shoulders, and then the fingers. There is loss of pain sense; tactile sense is not lost to such an extent as in the other case, but it is impaired. He distinguishes between tactile and pain sense. His pupils are contracted.

We will now ascertain the conditions of the color sense of these two patients. We have here four blocks of four different colors. In some cases of locomotor ataxia a very important symptom is the loss of color-sense,

red and green being lost first. Color-sense in these two patients is good. The first patient has a sensation of something tight around the body as a rope or band, the so-called "band sensation." Occasionally in the history of the disease, one of the most disagreeable and uncontrollable symptoms is what is called the "gastric crisis," that is continuous vomiting with pain. The pain is like that experienced in other parts of the body; it appears and then suddenly disappears. So the nausea without the slightest provocation will sometimes appear and abruptly stop.

Treatment.—In the early history of these cases, before the ataxia is manifest, when you can recognize by certain symptoms the beginning of the disease; when, in other words, you have an impairment of the reflexes, disturbance of color-sense, dysæsthesias throughout the body, impairment of tactile and pain sense, mental depression and irritability of disposition, severe localized pain—you may do something for the relief of your patient and sometimes cure him. If you treat the disease vigorously in the pre-ataxic stage, you can every now and then arrest it. You do this by putting the spinal cord as near as possible in a state of absolute rest. Put your patient to bed, keep him in the horizontal position; by judicious massage and Faradic exercise of the muscles prevent the possibility of their wasting; give him, at the same time, such internal treatment as is indicated and in accordance with the etiology of the case. If you are satisfied the case is specific, give anti-specific remedies, and the best is perhaps Donovan's solution—liquor arsenici et hydrargyri iodidi. If there is no specific history the treatment should consist of nitrate of silver, in doses of one-third of a grain, rubbed up with cosmoline to prevent decomposition, and given before eating three times a day. This can be continued two months without any danger of producing discoloration of the skin; then after an interval of two months another course may be given with safety and sometimes with benefit. Phosphide of zinc will sometimes benefit these cases.

The constant galvanic current to the spine and the Faradic brush to the body is also generally of service. The actual cautery to the back will occasionally relieve the pains and probably delay the progress of the disease.

Lateral Sclerosis.

Please notice the difference in the locomotion of this patient as compared with the other two who just appeared before us. He walks without any special effort of widening his base or disposition to bring the heels down first. He is 34 years of age, and says he had typhoid fever and inflammation of the liver some three or four months ago. He says his limbs are not as strong as they were. They feel stiff, and the muscles are rigid. He gets tired easily in walking; they, the limbs, feel heavy and are moved with difficulty. We test the patellar-tendon reflex as before, and find it much exaggerated in both limbs; we examine the limb for ankle clonus by flexing the foot suddenly upon the leg, and you see that it has set up a rhythmical tremor. We will have him, while in the sitting posture, work his leg up and down upon the foot. Having started the movement, you notice he cannot stop by a simple exercise of the will; consequently we have in this case a loss of power of the lower extremities, the exaggeration of patellar-tendon reflex, and the ankle clonus. There is no impairment of tactile sense, and no impairment of pain sense. The weakness and stiffness of the lower extremities, the exaggeration of the reflexes, and the ankle clonus, the absence of any particular sensory disturbance, pain or touch sense, make this case one of *lateral sclerosis*.

The treatment of this disease is practically the same as for locomotor ataxia.

Case of Paraplegia.

We have one more case to which we ask your attention. The patient is forty-five years of age. Fifteen months ago he was perfectly well. He tells us he was driving in a very exciting race; and when it was over and he tried to get out of the sulky, he found he had loss of power of the lower limbs. He had at the time of the seizure acute pain in the back, and for about a year numbness of both legs. There was also paralysis of bladder and rectum, for some weeks after the seizure.

His legs, you notice, are very much wasted, and that the paralysis is complete. Sensation is diminished, but he says that it is improving.

Spinal Apoplexy.

The atrophy of the limbs suggests anterior acute poliomyelitis. We differentiate by the instantaneous onset, the sensory disturbance, and the involvement of bladder and rectum.

As to the treatment of paraplegia, something can possibly be done in the way of restoring muscular power to the lower extremities by the use of massage and electricity. Electricity and massage offer the only possible chance of benefit to such patients. If the limbs respond to an interrupted galvanic cur-

rent; if you can make the muscles contract by such a current, then you can improve nutrition and benefit patients. But if you cannot apply the current in sufficient strength to produce muscular contraction, there is no advantage whatever in using electricity, nor hope of restoring function. Iodide of potassium and general tonics may be administered.

RUPTURE OF THE PERINEUM. PELVIC PERITONITIS

BY WILLIAM GOODELL, M.D.,

CLINICAL PROFESSOR OF GYNECOLOGY IN THE HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA.

The first case I have to show you this morning is one of perineal rupture, and I shall repair the injury before you. It is not what is usually termed a bad case; that is, the tear does not extend into the rectum. The large majority of these cases do not involve the whole of the sphincter ani. You should try not to allow such extensive tears to occur in your practice; but you will not always succeed. Yet you will generally escape having bad tears if you, as a rule, will remove your forceps as soon as you have brought the presenting part so low down as to distend the perineum. Most of the serious tears are occasioned by the traction on the forceps when the perineum is the only remaining obstacle to delivery. All these ruptures should be sewn up immediately upon the completion of labor. I can hardly imagine an exception to this rule. If they are slight, a few words of explanation to the woman will remove any objections she may have, and a few stitches will quickly repair the damage with but little pain. If they should be more extensive, ether may be administered and a skilled assistant should be present. The condition of this perineum, which we now have to operate upon, does not seem to be as bad as it really is. The tear originally extended to the sphincter, but a certain amount of spontaneous healing has taken place, and we now have to deal with the following conditions: The hard, unyielding cicatricial tissue which has developed at the site of the wound, acts as a splint and keeps the entrance to the vagina open. Air enters and escapes from the canal with every movement. Its floor having been destroyed, prolapse of the anterior vaginal wall has occurred; and, in time, the posterior wall will follow, dragging the womb down with it. Even now she suffers from the bearing down sensations which constitute the chief source of complaint coming from these cases.

Previously to beginning the operation, the parts involved are freed from hair, since this is not only in the way during the operation, but it may get between the edges of the wound and interfere with or prevent union. Having determined where the upper margin of the perineum should be by bringing the edges of the cicatrix together, we are ready to proceed with our work. You will find that the perineum is probably the most sensitive portion of the body. It has an abundant nerve supply and you can see now, that although this woman is thoroughly under the influence of ether, yet she winces as the knife enters the tissues. It becomes even more sensitive than usual when, as is the case here, a mass of dense cicatricial tissue is present. I begin by dissecting off on one side a small horseshoe shaped piece of the cicatrix, and then, passing my finger into the bowel to prevent cutting into it with my knife, I dissect up a flap, or pouch, of vaginal mucous membrane, which you can see projecting into the wound. Having done this, I trim the edges of the whole wound, and make the outlines of each side as like as possible. Now I am ready to sponge off the bleeding surfaces and insert the sutures. I have tried almost all of the many operations that have been devised for ruptured perineum, and I must confess that this one receives my preference. By it a thicker and stronger perineum is obtained than by any other. I save all the tissue that can be of any use in increasing the bulk of the perineal body and adding strength to its floor. I have removed, as you have seen, only one little horse shoe of the cicatrix and have utilized all the rest. I have simply dissected up one large flap from the hind wall of the vagina and from the sides of the vulva, and the raw surfaces are now ready to be brought into apposition. This operation not only procures a thick floor for the perineum, but it has the additional advantage of not having any cicatrix inside of the vagina. I have never failed to gain perfect union. Some time since, I performed this operation upon a patient from New York. Several months afterwards she became pregnant and I recommended her to the care of a friend of mine in that city. This gentleman, writing to me subsequent to her confinement, and referring to the new perineum which I had made for her, said that "the only fault he had to find with my operation was, that the perineum was *too good.*" In other words, the labor had been delayed when the presenting part of the child had reached this point,

and it was only after several slight lateral incisions had been made, that the perineum yielded sufficiently to permit the child to be born.

For sutures in these cases I use the thinnest possible wire compatible with safety. In this woman, who is rather spare, I shall use No. 29; in fat women I use No. 27. My first two sutures are buried deep in the body of the perineum and do not show in the wound at all. The upper sutures, on emerging from the left side of the vulva, in which they are first inserted, are passed through and buried in the vaginal flap before they enter the opposite side of the vulva. Now that they have all been inserted, you can see that even before they have been drawn taut, I have thus gained a back wall to my perineum. The sutures may be left in certainly for a week, and I don't object at all to ten days, particularly in those cases where some degree of tension is needed in order to bring the denuded surfaces together. I have used six sutures here and you notice that they occasion some little tension. Where the wire is fine, however, this need cause you no uneasiness; for, should the wire cut, the tissues heal behind it as rapidly as they are severed. Now, we dust the wound with iodoform and the operation is concluded.

Do not syringe out the vagina! I have two reasons for giving you this piece of advice. The first one is, that in order to use your syringe you must lift the patient upon a bedpan, and the traction upon the perineal muscles to which this movement gives rise tends to separate the edges of the wound. My second objection is, that the nozzle of the syringe is very liable to interfere with the union at the upper stitch. In the after-treatment of these cases, I endeavor to get along with as little opium as possible. Its use as a routine measure is, I have come to believe, deleterious; and, therefore, I administer it now only when it is really necessary, and then only in just sufficient amount to secure its desired effect.

Secondary hemorrhage after this operation is of exceedingly rare occurrence. In all of my own experience I have had it happen but twice. The first of these cases was that of a woman upon whom I had operated in the afternoon, and to whom I was called early the next morning. I found a pretty free hemorrhage in progress, but it was easily and quickly controlled by the pressure of a sponge which was introduced just within the entrance of the vagina. The flow of blood probably proceeded from some vessel which had not been included in the sutures. The second case was one almost precisely similar to this, and the hemorrhage was checked in the same simple way. The pressure exerted by the sutures is nearly always sufficient to prevent any bleeding, and, when it is not, the use of a sponge in the above manner will be found all that is necessary. The sponge stops the hemorrhage by pressing firmly upon the mucous flap which forms the back wall of the new perineum.

Pelvic Peritonitis.

Widow, 25 years old. Has one child. Husband has been dead five years. She has just been admitted, and no one has examined her, but she states that her physician calls her disease *acute peritonitis*. Let us see. Her pulse is 120, but, gentlemen, its acceleration is due to nervousness; it is a pulse indicative of fear—not fever. With the exception of this rapidity, it has none of the characteristics of the peritonitis pulse. Her tongue, also, is totally unlike that which usually accompanies this disease. The tongue of peritonitis is denuded in the centre, it is red and raw, never coated, but unnaturally clean and dry. Now, I shall examine the patient, and, I find, that she indeed *has* peritonitis, but it is not general nor is it acute. It is, on the contrary, localized and subacute. I detect on either side of the cervix a dense mass of tissue which feels like so much tallow. Pressure gives her acute pain, and I conclude that we have here the fruits of a circumscribed peri-uterine inflammation, a pelvic peritonitis. (Patient removed.)

What has caused it? Well, this is hard to say; but, a very common cause of this malady in the lower classes is gonorrhœa. Just before she was taken out, I asked her in a whisper if she ever had this disease, but she denied it. Such denials, however, are to be received with a good deal of caution, and particularly in this class of patients which feeds our clinic. Still, to give her the benefit of the doubt, such a complication may result from a cold caught while menstruating, from attempts to induce abortion, from the introduction of an unclean sound, or from other causes wholly innocent in character. There is one good feature about the virus of gonorrhœa and the pelvic inflammation to which it gives rise, and that is that it is almost always superficial in its action and that it does not penetrate deeply beneath the surface and end in troublesome abscesses. Peritonitis occurring as the result of other causes frequently ends in an abscess, which is liable to point and rupture into the rectum or vagina. Yet, often, all traces of the pelvic inflamma-

tion will vanish and the woman may again be restored to perfect health. Not so, however, with the products of gonorrhœal inflammation, which rarely form abscesses; although pus may be found in the tubes and ovaries. Very firm adhesions are the usual outcome of this variety of peritoneal inflammation, and, in this peculiarity, I think, we may find an explanation of the well-known fact that prostitutes are commonly sterile. Almost all of them at one time or other have had attacks of gonorrhœa which are accompanied by localized peritonitis. This may be very slight; perhaps, indeed, the woman may not be conscious of her additional trouble, but it will leave its traces in displaced ovaries, adherent tubes, flexions of the uterus, etc., and it is these which interfere with conception.

COMMUNICATIONS.

FIRST IMPRESSIONS OF UNDEVELOPED DISEASES, AND FIRST TREATMENT.

BY ENOS T. BLACKWELL, M.D.,
CEDARVILLE, N. J.

There is no truth more potent to the observing physician than that many ailments present themselves to him primarily in such an imperfect form as to task his diagnostic powers to the utmost; and, that at times, his keenest erudition leaves him still in doubt to what nosological class he shall assign the specimen before him.

The careful physician will, therefore, be wary how he enters upon the treatment of obscure cases, lest, while endeavoring to cure, he really injure his patient's chances of recovery. Much depends, therefore, on the physician's first view of cases of this character; and his success must largely depend on his ability to read aright the scanty indications that are furnished him.

There is no disease, perhaps, which is more apt to mislead the practitioner in this regard than typhoid fever. Sometimes it presents itself as an open specimen of malarial fever, with its typical phenomena of paroxysm and recession. There may be nothing in the appearance of the skin, the tongue or in the facial expression that suggests a dangerous affection. There may be sluggishness, or even constipation of the bowels. Should there be some evident disturbance of the liver and stomach, with dark color of the skin, he may be quite confident in a diagnosis of paludal fever, and govern himself accordingly. If he proceed to use medicines adapted to the fever alone, and leave the apparent secretory trouble for further observation, without attempting to combat it by active cathartics, I think he will not regret it.

Should he prescribe some mild laxative, no damage may be done, or even positive benefit ensue; but, should he give active purges, with a view of arousing the emunctories, he may have most violent catharsis and consequent injury, if his disease should prove to be enteric in character. The affection of the glands of Peyer may have been so moderate as to have caused neither diarrhœa, nor suspicion of disease there; but, an active cathartic having been exhibited—especially if it be of a resinoid nature—there is developed a most painful and harmful diarrhœa.

In reviewing my own experience in typhoid fever—an experience generally of success—I recall two cases in which from insufficient knowledge, I gave an active cathartic—calomel and podophyllin—with the idea of loosing the emunctories beneficially; but, unfortunately, with injury to the patient. One of them was a young medical student returning in spring from close attention to medical lectures, and from fearless investigation among the fever-stricken patients of Bellevue Hospital. He was listless and unable to study, and his skin had a decidedly darkened color, which was attributed to biliousness. He proposed to "work off" his indisposition in the garden; and to assist in this laudable undertaking, received a full dose of podophyllin and calomel. The result was hypercatharsis, and great reduction of strength. His disease proved, when fully formed, a most violent infectious fever, of which he died. A like result occurred in the other case, which also proved fatal.

It will be well, then, for the physician, who has a patient too ill to labor, and disinclined to take to his bed, especially if this condition has existed for several days, to be careful in the exhibition of active purges with a view of clearing the intestines and unlocking the secretions, even if indications seem to suggest them. There is much difference of opinion, too, as to what constitutes a mild aperient suitable for an initial disease. That castor-oil, when given in full dose causes paroxysms of pain, when the expulsive throes come on, no one can doubt who has ever taken the medicine. A suitable remedy, taken in small and often repeated doses, will open the bowels with less irritation and distress than a larger portion exhibited at longer intervals. It is doubtful whether any medicine will give better results than calomel, in

grain or half-grain doses, repeated every two hours until an evacuation take place. By this means the bowels are gently persuaded, and not violently coerced with consequent irritation and distress.

If, therefore, in making acquaintance with a recently presented specimen of disease, we study its demeanor and characteristics, waiting patiently the unfolding of its true nature, we may gradually come to know its quality, and settle deliberately to a sensible and rational treatment. We shall thereby avoid any charge of rashness in any opinion we may give, or any treatment we may institute; and be guiltless of unsuccessful practice founded on insufficient investigation. Our patient, also, will derive the benefit that is to accrue to him from the services of a self-poised and scientific dispenser of the healing art, instead of one who daily changes his opinion of the nature of the distemper under observation, and the treatment suitable for its cure.

DEATH FROM EARLY SEPTICÆMIA FOLLOWING A PUNCTURED WOUND OF THE TOE BY A SPLINTER—A LESSON IN SEPTIC SURGERY.[1]

BY W. W. KEEN, M.D.,

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I. T., aged 26, a steel engraver. While walking across his floor at 8 P.M. on Thursday, February 9, 1888, a hemlock splinter pierced his shoe and punctured his left great toe on the inner side opposite the phalangeal articulation. He did not return home until 11 P.M., as his foot did not hurt him badly. A doctor was then called who thought he removed the entire splinter. Eight days later, however, another piece, one inch long, which had remained undiscovered was discharged spontaneously. The wound was dressed with lead water and laudanum, with some carbolic acid.

February 10. Dr. Bartleson, his regular physician, saw him the next morning, found the toe slightly inflamed, but not tender, and the splinter presumably removed. The only symptom was a severe pain extending up the leg as far as the hip, which was quieted by a moderate dose of morphia.

On the morning of the 11th, and therefore only thirty-six hours after the original injury, his temperature ran up to 104.5° F., with great pain in the left-shoulder joint. For several days his temperature ranged from 102° to 104° F. It was somewhat reduced by antifebrin from time to time.

Both shoulder joints soon became painful; and a chill occurred on the 13th.

February 24. I saw him in consultation with Dr. Bartleson. The toe was scarcely at all red. It was moderately tender, and a small opening existed at the site of the wound with a very slight discharge.

Manipulation of the toe, however, showed me that the joint was hopelessly diseased; the cartilages were gone; the grating of the bone was very perceptible on the least movement, and the ligaments were entirely destroyed. I immediately amputated the toe at the metacarpo-phalangeal joint. The wound healed kindly within a week without any inflammation. Both shoulders were tender, but not visibly inflamed or swollen. A few days later both knees became tender. The pain in both shoulders and knees yielded to an ointment of equal parts of ichthyol and agnine. His temperature under quinine (twenty grains a day) ranged from 102° to 103° until March 3, when it again rose to 104°, accompanied with much sweating, but no further chills. Antifebrin moderated it, but produced such exhausting sweats that its use was abandoned. He had, also, complained of a moderate pain in the belly, with slight tenderness. He had had no intestinal troubles.

March 5. He was suddenly seized with right hemiplegia; became unconscious early the next day, and died at 8 P.M. on March 6.

Post-mortem examination March 9, 1888, at 3 P.M., sixty-seven hours after death, Drs. William Osler and George Dock assisting. The body was emaciated; *rigor mortis* well marked.

Chest.—There were two drachms of fluid in the pericardium. There was a slight ecchymosis on the left side of the heart anteriorly near the apex; the heart was filled with blood almost entirely fluid; the right side showed endocarditis, with abundant vegetations on the three tri-cuspid segments. Some of the chordæ tendineæ of the anterior flap were destroyed. The ecchymosis corresponded to an infarct in the substance of the wall on the left ventricle. The anterior coronary artery was plugged. No vegetations on the left side. There were infarcts at the roots of both lungs, especially the right.

Abdomen.—There was no general peritonitis, but a circumscribed local peritonitis existed on the anterior wall of the stomach,

[1] Read before the College of Physicians, April 4, 1888.

towards the spleen. There were a few small infarcts on the walls of the small intestines and cæcum.

The spleen was enlarged and soft, with one infarct at the upper end, soft, and of the size of a chestnut, with a congested zone around it; one below, pale, the size of a cherry and rather hard. Below this last, four or five small, pale infarcts. Occupying the entire middle quarter, and extending throughout the entire thickness of the spleen, was a large hemorrhagic infarct, with soft dark contents. The rest of the spleen seemed soft.

Kidneys.—Both kidneys were slightly enlarged; stellate veins prominent. Capsules only moderately adherent. Infarcts in each kidney.

Brain.—Pacchionian bodies were very well marked; no meningitis at the base of the brain. Arachnoid slightly turbid. The left tempero-sphenoidal lobe a little yellowish; the left Sylvian artery had firm clots in all three of the main branches, at the point of division; they were greyish white in color, with dark almost black color in parts; one a little yellow. On cross sections of the brain there was found a large apoplectic softening in the corpus striatum of the left side, destroying the entire caudate nucleus, and the anterior half of the lenticular nucleus, with spots of slight disseminated hemorrhage in the posterior half. The internal capsule was slightly yellow posteriorly, invaded by hemorrhage to some extent anteriorly, but generally quite distinct in color from the hemorrhagic nuclei on each side of it.

Dr. Dock made some cultures from the heart and spleen and found only the streptococcus pyogenes, no staphylococcus. Hence probably the multiple thrombi without the septic metastatic abscesses.

Remarks.—It is rare that from so slight a cause, apparently, such extensive lesions in all parts of the body should follow, and especially that septicæmia should set in so early, and violently. Only twelve hours after the injury was received pain existed in the entire leg, presumably from early invasion by the lymphatics; within thirty-six hours after the injury, the left-shoulder joint was involved, the temperature rose to 104.5°, and was followed speedily by a chill, the involvement of other joints, and, after a comparatively long illness, by death. The infectious endocarditis of the right side was a typical lesion. Associated with this (as has been shown in the history) were infarcts in the brain, heart, lungs, spleen, kidneys and intestines.

This case may teach us two most important lessons: 1. The danger of delay even in slight wounds. Three hours elapsed between the receipt of the injury and any surgical attention, and that of the most superficia character. Within that time doubtless the mischief began. The local trouble, however, was at no time serious in external appearance. When I first examined the foot on the 15th day and found the joint entirely destroyed, with the exception of a small almost uninflamed opening caused by the splinter, and a drop or two of pus, the toe looked perfectly normal. Yet even in so casual and apparently unimportant a wound with so little local trouble the infective process ran an extraordinarily rapid course.

2. It teaches us the absolute importance of careful, thorough and antiseptic surgery. The proper course to pursue would have been to etherize the patient (or cocaine might have been used), and to make a free incision at the site of the wound, so as to be sure that the entire splinter was removed immediately; and, as the wound was so near a superficial joint, to determine the fact whether this joint was involved or not.

Next, and equally important, the wound should have been most carefully disinfected, and an antiseptic dressing applied. Had the patient sought surgical advice at once, and had thorough surgery and careful antisepsis been used, it is probable that he would have recovered without any serious trouble.

That he was personally a blonde, with a suppurative tendency; that his father had suffered for eighteen months with suppuration following an injury near the knee from a tack, and that his sister had suffered for six weeks from a palmar abscess, make it possible that suppuration, and even death, might have occurred in spite of the utmost precaution. But the existence of this tendency, personally, and in the family, would be the very strongest possible reason for *extra* precautions to prevent any septic trouble.

Until surgery becomes an exact science (a comsummation in the far distant future, I fear), we cannot say that a different result would *certainly* have followed had antiseptic methods been used; but we *can* say, that without them he was certainly doomed to trouble, and even, as the result showed, to death; and that with them his chances would at least have been extremely good.

The culture experiments of Dr. Dock were of interest, showing the nature of the infective coccus present.

—The *Lancet*, April 14, 1888, announces the publication of a weekly journal called the *Nursing Record*.

A CASE OF MULTIPLE NEURITIS (SPORADIC BERI-BERI?)

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The comparative rarity in this country of typical cases of multiple neuritis, unconnected with diphtheria or with arsenical, saturnine or alcoholic poisoning, and recent changes in the views of the pathological nature of certain palsies and atrophies, renders the details of the following case worthy of special record. That a recovery from the acute attack has prevented our adding the post-mortem appearances to the clinical details, is doubtless largely due to the appropriate treatment of the onset of the disease by the attending physician, Dr. B. C. Snowden, of Olney, who subsequently referred the patient to my care.

By way of preface, it may be added that we were totally unable to assign an adequate cause for the attack of this unique disease, unless, as suspected by Dr. Snowden, the first manifestations were rheumatic, and the attack itself a sequel. There was, however, no rheumatic history whatever preceding the pains of the attack. As to the influence of cold and damp, this could be easily assigned considering the exposure incidental to the patient's occupation as a farmer; but, on the other hand, the first attack was in August, and neither could be traced to any unusual exposure. The question of poisoning from various sources was early canvassed, with negative results.

M. W., a vigorous and robust farmer, aged 30, married, had always been in the best of health until the present attack. His mother died of laryngeal phthisis at 66, his father of paralysis of the stomach at 67, and a brother of phthisis at 26. Three brothers and two sisters are living and healthy, save that one brother is troubled with hay-fever. No other relatives have been the subject of nervous diseases.

In August, 1887, while putting a bridle on a horse, his arms showed sudden weakness, and he experienced pain and soreness in the right biceps. This increased in severity and lasted for several days, and at the same time was accompanied by similar pain and weakness in the left leg and foot. The foot became œdematous, especially over the instep, where it was also red and exquisitely tender. He was confined to the house several days, but the pain and paresis lasted five weeks, leaving the arm and leg atrophied and weakened. From this time until early in January, 1888, he continued to improve in the two weakened members, which felt worse after prolonged exercise and in the morning, and evening, being "eased up" by motion. In December, had an attack of diarrhœa. On January 13, 1888, while in the field, his feet began to pain him, and he noticed weakness in both legs below the knees. He continued to supervise the work for the remainder of the day, although the legs and feet were unusually cold. That night he found he had lost the power of motion in all of the toes. He slept well, and in the morning was assisted to sit up and dress by his wife, but on attempting to stand fell back suddenly on the bed. Being a man of great persistence, he at last succeeded in going down stairs with his wife's assistance, and ate his breakfast at the table. He then attempted to go out alone, managing to get twenty yards from the door when he fell helpless and was carried back to the house. It is thought that at this time he fainted, as he did not recognize Dr. Snowden when the latter reached him, although he recognized a clergyman who called later. He passed a comfortable night with pain in the legs only, and sat up in the morning with help, but the pain in legs and arms became worse and continued most intensely for five days. There was a dropping and tingling sensation with great soreness accompanying the pain in the forearms and legs, and total paralysis of the arms below the elbows and of the legs below the knees. He could flex the arms slightly and move the shoulders and all trunk muscles, but could not feed himself for two weeks. In three weeks he got on his feet with assistance, and attempted to step in seven weeks, but would fall suddenly after a couple of steps had been taken. At no time during the attack was there girdle sensation, disturbance of the bladder or rectum, or pains about the body.

At the end of eight weeks, his condition remaining somewhat stationary, he was placed under my care, being admitted into my private hospital March 8, 1888. His condition on admission was as follows:

Beyond slight emaciation, his general health was good, bladder and urine normal, bowels somewhat constipated (an old habit) and complexion good. Being unable to walk, he was carried into the institution. He could make all movements of the wrists and hands, but they were too weak to handle a knife in cutting up food, or even to press the spring of an electric button. Dynamo-

meter zero for each hand. Movements of elbows also feebler than normal. No movements in toes of either foot, nor in the extensors of the foot; slight movement in the calf muscles. All movements of the knees, hips and trunk normal, except in the gluteal and hamstring muscles, which are feeble; limbs soft, flabby and wasted.

The electric reactions were exceedingly interesting, showing not only the degeneration reaction in the completely and partially paralyzed muscles, but also slight shades present in muscles of the arm that responded normally to the will.

Nerves.—The ulnar and median nerves of both arms and the peroneal and posterior tibial nerves of both legs showed marked De. R., no strength of the Faradic current producing the least response, and the serial and modal changes in the galvanic response being marked.

Muscles.—The intrinsic muscles of the hands and feet showed the most profound change in electrical behavior, no response whatever appearing to Faradic currents, the galvanic response being quantitatively increased and the normal order transposed to An. Cl. C″—Ka. Cl. C′. The minimal anodic closure contraction appeared at 3 ma., the kathodic at 5, with a large active electrode. The modal change was even more profound, the response occurring in a slow, wave-like manner. Similar conditions in lessening degrees were found in all muscles of both arms below the elbows and in the ant. tibial and peroneal groups of muscles of both legs. In the left leg the calf muscles were also unresponsive to the Faradic current, and showed galvanic changes, but in the right calf a slight glimmering response appeared to the Faradic. The hamstring muscles showed partial De. R., although responsive to the will, which was also true of the gluteal muscles. The quadriceps muscles of each thigh responded normally to both currents. Above the elbow, the arm muscles showed slight diminution of the normal Faradic excitability. All other muscles of the body were normal.

Sensation.—There was some hyper-algesia on the anterior surfaces of the leg, and diminished tactile sense on the dorsal surfaces of the feet. The tactile sense was normal in the hands and arms, but the pain sense was slightly diminished on both surfaces of the hands. The patient had not suffered from pains for some time before admission.

Reflexes.—The knee jerk was abolished in both legs, and the cremasteric reflex was absent. The skin reflexes were unaffected.

Nutrition.—The finger-nails and the toe-nails showed no change in rate of growth. The skin was not glossy as in isolated neuritis, but there was extensive exfoliation of the cuticle on the plantar surface of the feet.

Appropriate doses of strychnia, pyrophosphate of iron and quinia, which he had been taking, were continued, and he was put on labile applications of the galvanic current —20 to 30 ma.—daily, massage, the salt glow and almost absolute rest. At the end of four weeks the following improvements in his condition were noted: Dynamometer, right hand, 10 pounds; left hand, 16 pounds. He was able to walk down stairs with but little assistance. The third and fourth toes of the left foot and the right little toe moved slowly to the will. The Faradic current now produced a faint glimmer in the anterior tibial group of the right leg and in the right hamstring muscles. In the left leg faint contractions to this current appeared in the peroneal, gastrocnemius and hamstring muscles, but none in the anterior tibial. The patient's home affairs demanding his personal attention he was compelled at this point to intermit further treatment and return home, able to attend to his business to a certain extent.

There is no doubt that cases of this sort have been frequently mistaken for anterior polio-myelitis of the adult, the paralysis and electric reactions being in some respects so identical, but the facts that point to a purely peripheral neuritis of the affected nerves in this case are: The escape of the anterior muscles of the thigh which were almost invariably involved in the large number of cases of polio-myelitis that have fallen under my observation, and the fact that *all* the muscles supplied by the sciatic nerves were more or less affected. In polio-myelitis associated muscles supplied by different nerves are similarly affected by disease occurring at the center of the association in the cord (the large ganglion cells of the anterior cornua); in multiple neuritis the muscles supplied by a certain nerve are attacked, and those supplied by the most distal parts of the nerve fare the worst.

Speculation as to the cause of this attack has been so far fruitless, the only reasonable supposition involving a sporadic case of a microbic disease, such as is said to be endemic and at times epidemic in parts of India under the name of beri-beri, and in Japan under the name of kak-ke.

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THERAPEUTIC VERSUS MEDICAL DIAGNOSIS.

BY L. HUBER, M. D.,
ROCKY FORD, COLORADO.

The comprehension of the history, cause, and development of symptoms in any particular disease is embraced under the term *medical diagnosis*. In other words, medical diagnosis is simply a cognizance of particular diseases in their entirety. This power is essential to the classification of diseases. It is a kind of synthetic process that the trained mind readily performs. Over and against this, there is another mental process highly useful to the practitioner of medicine. It is *therapeutic diagnosis*—a species of analytic knowledge that comes with experience.

To distinguish these two processes, and accord each its place, I will cite a case. Arther R——, aged 11, was brought to me suffering from attacks of diarrhœa. Practically, this was the only thing of which he complained. In investigating the case I found these conditions: Pain in the lower dorsal region, preceding the diarrhœa; tenderness over a circumscribed area of that part of the spine; when the diarrhœa supervenes, there is entire loss of power to control the evacuations. After these attacks all these symptoms abate for a day or two. From these data I conclude the case is one of circumscribed congestion of a portion of the spinal cord with partial paralysis of the inhibitory functions of the lower bowel. This is not a classifiable disease, but rather a *disease-condition*. My *therapeutic* diagnosis considers it as such. I now look upon the diarrhœa as a symptom with an outlying cause. This is different from considering it a disease, the cause thereof lying in or directly acting upon the intestinal canal or some of its auxilliary emunctories. In applying remedies I regard the therapeutic diagnosis solely. I endeavor to remove the causative spinal lesion. Ergot and belladonna are administered and a direct result is obtained. This confirms the view taken and the correctness of the analysis made. Other remedies had been fairly tried, before this case came into my care, but without any effect, furnishing therein a still further confirmation of the correctness of the therapeutic diagnosis.

Again, among chronic phthisical patients, there are occasionally present attacks of dyspnœa. These may be mild or severe. In those cases in which there is considerable solidification or contraction of lung tissue, with very little softening or breaking down of the same, this mild dyspnœa is attended with an unbearable, irritable heart-action. This latter condition may be interpreted in two ways. First, it may be due to capillary congestion of portions of the lung tissue. The feeling of weight and discomfort over the affected portions of lung would strongly indicate this condition. Moreover, a moderate hemorrhage now and then, when this sensation is experienced, often relieves not only the feeling but also the dyspnœa and the belabored heart-action. On the other hand, the volume of circulation in a consumptive being diminished, the tone of the system lowered, and consequently the accelerative force of the heart weakened, mild congestion passive in character, and dyspnœa naturally follow. Whichever view be adopted, it follows that the medication must be somewhat different. The writer inclines to the first chain of phenomena given. These constitute his *therapeutic diagnosis*. Accordingly he obtains good results from cimicifuga, or ergot, or he combines a few drops of aromatic sulphuric acid with small but frequent doses of digitalis. He aims to remove the congestion of lung tissue, and accomplishing this the dependent symptoms quickly disappear. It is true the remedies employed are not without their regulative effect upon the cardiac apparatus. The case, however, shows the point in question, viz.: the difference between the medical diagnosis, which makes the disease to be phthisis pulmonalis; and the therapeutic diagnosis, which analyzes the present condition of the patient and suggests the proper remedies to improve it.

The two terms are placed at the heading of this article as apparently antagonistic. This is not meant. They are simply conceived to be contrasted. Both medical and therapeutic diagnosis are essential to success in medicine.

The extensive experimental study of physiology at the present time, the development and adoption of the physiological rather than the purely clinical study of therapy, the greater familiarity of the profession with the natural history of many diseases, all combine to simplify therapeutic diagnosis. These facts find an illustration in the symptomatic and antiseptic treatment of certain fevers. Suppose two physicians hold counsel in a case of typhoid fever, in which the temperature has risen above the safety limit. Both agree in the medical diagnosis as to typhoid, but as to therapeutic diagnosis they differ. One proposes for the reduction of temperature quinia in large doses, or veratrum viride, or

the tepid or cold bath. The other looks upon the hyperpyrexia as due to a large amount of septic material being absorbed from the intestinal tract, and proposes the bath for temporary relief, and antiseptic agents, as carbolic or some other acid, or iodine, to destroy the toxic matter.

The field of therapeutics has always afforded many and warm contentions. Were disease conditions better described and remedial agents selected and classified accordingly, by our standard authorities, it is certain that there would be less difference of opinion. Works on practice too often stop with general principles. Medicine having grown up as an empirical science, the principles are inductive. The student in order to comprehend these generalizations must comprehend the body of facts from which they are deduced. Hence the treatment of particular diseases should be written up on the basis of therapeutic diagnosis.

Within recent years great improvement and progress have been made in works on therapeutics, mainly in that individual agents are studied and their physiological effects carefully recorded. Moreover, their therapeutical applications are given rather in reference to disease-conditions than diseases in their entirety. In other words, therapeutic diagnosis is regarded, and remedies described accordingly. That this is a mark of progress few will deny after reading what has been previously said.

DIPHTHERIA.

BY P. J. FARNSWORTH, M.D.,
CLINTON, IOWA.

Very little, if any, advance has been made in the pathology or treatment of diphtheria since Bretonneau investigated it in 1826. Nearly all the modern literature follows him very closely, both in description and treatment. We have changed our form of iron, and perhaps added chlorate of potash, but that was the fashion twenty-five years ago. Besides that, we ring the changes on stimulants and supporting treatment, and assert that it is a local disease with constitutional symptoms, or a constitutional disease with local symptoms.

It appears in widely separated localities, though it seems to have made its home in some of the large cities. The mortality in some epidemics is forty or fifty per cent., then it comes down to four or five, and the practitioners give themselves the credit of curing the disease, and rush into print with their methods: iron, chlorate of potash, alcohol, bichloride, or mild chloride, of mercury, with or without local treatment. It is probable that as many cases would have recovered with some attention to ventilation and lemonade for medicine, as from all the so-called successful treatments.

There are many reasons for supposing that it is at first a local disease, arising from some spore floating in the atmosphere, finding lodgment and an appropriate soil in the throat. It sometimes plants itself on a burned or blistered surface, when there is no disease of the system. When bacteria were discovered as the cause of disease, the bacterium or micrococcus of diphtheria was sought, and found in abundance, on and about the membrane, but contrary to expectation these when transplanted would not produce the disease. The membrane may be transplanted and flourish, but the microbe is an accompaniment rather than cause—something that seems to follow.

The membrane under the microscope appears like a coagulum growing in the substance of the gland, involving the mucus tissue and having beneath a fibrous tissue. If these are not the roots of the membrane they are exhausted or necrotic fibrin. It is thrown off or may be pulled away, and a new membrane forms on the denuded surface. On an abraded surface on the outside of the body the membrane has the same appearance to the naked eye. I have never had an opportunity of examining any with the microscope. Effectually destroying this membrane cures the disease; perhaps if allowed to remain it would produce the same constitutional symptoms that it does in the throat. Some peculiar condition of the surface, either alkaline or acid, or a condition of inflammation, is required for the cultivation of the disease, for many throats and many blisters escape it during an epidemic. A mother in my practice had diphtheria severely; the membrane formed and reformed many times on the tonsils, and then passed down the trachea. It was coughed up in ribbons and then in a cast coming from as low down as the bifurcation of the bronchi. From weakness partly, and from extension of the membrane into the lungs, she died. Three days before death I found her nursing her child. Neither the infant nor another child, nor any member of the family had the disease, and no precautions were taken to prevent it. Yet when a sister came from a country where there was none of of the disease, forty miles away, to assist at the funeral, she took it in a week, having it in a mild form. It was in cold weather, and the

disease spreading from this patient followed one street of the city, until there were a hundred cases, and forty deaths. Some sporadic cases followed the next year, but since then the city has been free from it for ten years. It prevails in many towns of this State, and in some in a virulent form. In some places it has lingered two or three years. It is not a disease of filth or sewage; it goes into the best houses and the healthiest parts of towns. I have made the suggestion that it is a fungus of a higher order. Will some one who has knowledge and opportunity direct his attention to it and endeavor to elucidate some new law that will lead to new treatment?

Society Reports.

OBSTETRICAL SOCIETY OF PHILADELPHIA.

Stated Meeting, Thursday, April 5, 1888.

Thomas M. Drysdale, M. D., in the Chair.

Dr. T. M. Drysdale reported a case of

Multilocular Papillomatous Tumor of the Broad Ligament; Operation; Death.

At the request of her physician, Dr. A. G. B. Hinkle, I was sent for Jan. 7, 1888, to see Mrs. M. I. K., a widow, 54 years old. She stated that she was the mother of seven children, and that her labors had invariably been hard and tedious, accompanied with violent abdominal cramps. The menopause occurred when she was 46 years old. She had always been strong, worked hard, lifted heavy weights, and had had no sickness in thirty-five years until last March, when she was seized with intense pain in the abdomen, together with obstinate constipation. She continued to suffer for several weeks, and her physicians had great difficulty in getting the bowels moved. Medicines had so little effect that her life was despaired of, but she was finally relieved by copious purgative injections. Her disease was at first supposed to be owing to sewer-gas poisoning, as her son suffered in a similar manner at the same time, and they were treated accordingly, but finding they did not improve a consulting physician made a more thorough examination, and found well-marked blue lines on their gums. They were then treated for lead colic, and soon recovered. The son had remained well ever ince, but she had suffered from colic and onstipation, while the abdomen had continued permanently swollen. Her bowels never moved satisfactorily, as only a portion of the contents seemed to come away, leaving the upper part of the intestine full. Last August she first felt a hard tumor low down in the right side. Her abdomen since then had increased rapidly in size, while the rest of the body emaciated. Her appetite had been good, and she had no pains after her meals, but felt too full to eat much. She had constant eructations, but no vomiting. Until recently she had a slight daily movement of the bowels, but for several days past she had had no evacuation. During all this time she had suffered from what she supposed was colic, and, in fact, was never free from pain. Just before I saw her she had taken a dose of castor-oil, and at my visit was in great agony at the distention.

She was thin and anæmic, and her complexion had the cachectic appearance of malignant disease. The centre of her tongue was red and smooth. The abdomen was greatly enlarged, and resonant on percussion everywhere, except below a line half way between the umbilicus and pubis; there it was dull, and fluctuation could be detected. In the right iliac region I found a hard nodulated tumor which appeared to be moderately movable, but so rigid was the abdominal wall that it was difficult to determine this with certainty. The bladder was prolapsed and projected between the thighs, but the uterus remained within the shortened vagina, and was held up apparently by being fixed to the tumor. The uterine sound entered two inches, and passed to the right. As well as could be made out, the uterus and tumor were closely adherent. Rectal examination revealed a firm, immovable tumor occupying the upper part of the pelvis. The examination, although made with the utmost gentleness, caused great pain. As frequency of micturition was a prominent symptom, Dr. Hinkle had more than once examined specimens of her urine, but, finding nothing abnormal, concluded that the irritation was owing to the prolapse of the bladder. As usual before an operation, I also examined two specimens of the urine, and found it free from albumin and sugar, with a sp. gr. of 1020. She assured me that she passed the usual quantity.

The oil operated and gave her relief for twenty-four hours, but after this she grew rapidly worse, the symptoms of obstruction of the bowels increased, and by January 17, just ten days from my first visit, I was again sent for, and found that she had been in such continual agony that she had concluded

to submit to an operation. The abdomen was extremely hard, and in place of being tympanitic, was everywhere dull on percussion and fluctuation was general, showing that a rapid effusion of fluid had occurred.

In the presence of Drs. Hinkle, James F. Wilson, I. Howard Beck and G. B. McCracken, and assisted by my son, I operated January 22, 1888. The incision was followed by the escape of about a gallon of ascitic fluid. The peritoneum was slightly inflamed, and in some parts thickened. The growth proved to be a multilocular papillomatous tumor of the broad ligament. It filled the lower part of the abdomen on the right side, and occupied the upper portion of the pelvis. Its color was not the opaque white of an ovarian cyst, but resembled in this respect the intestines. The main cyst extended upwards as high as the border of the lower ribs. To this the omentum and a loop of intestine were firmly adherent. These adhesions were detached and the cyst drawn forward. As this was being done it burst and discharged a large quantity of red serous fluid; for, as usual, the cyst walls were very thin and easily ruptured. Two other large cysts below this were tapped, which greatly reduced the size of the tumor, but a mass of others remained, filling the upper part of the pelvis, to which they were firmly adherent. This was the portion which, by pressing on the bowel as it passed the pelvic brim, obstructed it. Here it was difficult to separate the tumor from the surrounding structures without injury to them, for it was adherent to the bladder, bowel and everything it touched. After freeing it from all its other attachments without doing mischief, save to some vessels on the floor of the pelvis, which bled profusely, I found it was firmly bound to the uterus, which it dragged down and held close to the anterior wall of the pelvis, deep down on the right side, by an exceedingly short, firm and vascular attachment or pedicle, which I ligated with great difficulty, owing to its depth in the parts. The tumor with its capsule was then removed. This revealed a set of bleeding vessels below the pedicle, which were secured after considerable trouble. Before closing the wound the abdomen was thoroughly cleansed by irrigating it with warm water which had previously been boiled. The operation was tedious, lasting over an hour, and through it all the pulse was well maintained, but it was followed by a profound shock, shown in the pale face and thready, almost imperceptible pulse. As soon as she became conscious she complained of intense pain in the back. Under the use of stimulants and the external application of heat she reacted in about an hour.

At 5 P. M., four hours after the operation, the nurse applied the catheter and removed an ounce and a half of urine. At 8 P. M. Dr. Hinkle and I visited her and used the catheter, but the bladder was empty. Her pulse was 112, temperature 100⅕°, which was the highest it reached. She complained of feeling sore all over. To relieve the suppression of urine, we ordered a mustard plaster, made with warm water, to be applied over the kidneys, and prescribed a tablespoonful of the following mixture, well diluted with water, to be taken every four hours:

℞ Potassii ascetatis.....ʒss
Spiritus ætheris nitrosi.....fʒss
Aquæ destillatæ.....fʒiiiss

10.30 P.M., she vomited for the first time. 12.15 A.M., after an ounce of urine was drawn, she became restless and complained of severe pains in the abdomen, which continued until Dr. Hinkle was sent for at 2.15 A.M. He found her with a pulse of 94, and a temperature of 100°, and gave her a hypodermic injection of one-sixth of a grain of morphia. After this she slept until 5.30 A.M., when the nurse drew her urine and obtained ʒss.

Monday, 10.45 A.M., pulse 118, temperature 98°. Since 7.30 A.M. had been in pain and had vomited several times. The catheter had just been used and about a teaspoonful of urine drawn. The abdomen was tympanitic, but not tender on pressure. The rectal tube was used which permitted a large quantity of flatus to escape. After this the diuretic was used by injection and retained. We directed one drachm of Rochelle salt to be given every two hours and, a hot vapor bath. 2 P.M., pulse 130, temperature 97°. Had vomited everything. A quarter of a grain of calomel and a tablespoonful of very hot milk were then given every hour. This quieted her stomach. At 4.50 P.M., one ounce and a half of urine was drawn. She continued drowsy but did not sleep. 9.30 P.M., one drachm of urine was removed.

Tuesday, 10.30 A.M., pulse 130, temperature 96°. Skin cool and pale. The catheter had been used at 2 P.M. and at 9 A.M., and each time about a teaspoonful of urine was obtained. The stomach continued quiet, until 9 A.M., then she vomited occasionally. Stimulants were used by the rectum, but she continued to sink and died at 6 P.M.

The autopsy was made the next evening by Dr. McCracken, who kindly furnished me

with the following notes of it: "The wound in the abdominal wall was firmly united throughout the whole extent. A moderate amount of peritonitis existed, confined principally to the lower part of the anterior abdominal wall and the lower coils of intestines, which were covered with a thin layer of pus. This was the portion of the peritoneum which was found inflamed when the abdomen was opened at the operation. The pedicle and surrounding parts from which the tumor was detached were in excellent condition. The right kidney was sought for but could only be detected after a prolonged search, when it was found to have been converted into a large, elongated cyst, only a small portion of the upper part of the organ remaining unchanged. It resembled a distended bowel so closely that it was difficult to distinguish it from the surrounding intestines. The left kidney was enlarged and intensely congested. When the adherent capsule was removed, the surface of the gland presented the rough granular appearance of inflammation. There were a number of small cysts in the cortical substance."

This case presents several features of interest, one of which was the steady decline in temperature from 100⅕° on Sunday to 96° on Tuesday morning. But I have brought it before you mainly for the purpose of showing how we may be deceived in regard to the condition of the kidneys, even when all signs of disease are absent in the secretions. This patient's life was dependent upon the active exercise of one organ, which itself was diseased and struggling under the load thrown upon it as the only eliminator of its kind in the body. It naturally followed then, that when the toxic effect of the ether was added to its burden, it yielded and the patient died.

Dr. Parish spoke of the toxic effect of ether on diseased kidneys and wished to know whether Dr. Drysdale had been able to determine the renal condition in this case. He had some years ago had a case of Porro-Meuller operation in which there was parenchymatous renal disease, and in which death resulted from acute suppression of urine. It was a serious question as to what anæsthetic we should use under similar circumstances. The tumor presented by Dr. Drysdale was peculiar for a cyst of the broad ligament, on account of the large amount of solid matter connected with it.

Dr. J. Price said there was but one authority who made any mention of the condition of the temperature under ether. Some years ago Dr. Burk had taken the temperature of a large number of patients under the anæsthetic, and found that there was invariably a depression of from one to two degrees, due to cessation of combustion. The symptoms of obstruction of the bowels as presented by Dr. Drysdale's case were very characteristic. He had lately been dealing with some very trying cases of this kind, and pain was always present and very severe; in several cases shock and collapse had been marked symptoms of the obstruction.

Dr. Drysdale did not think that the decline in temperature was due to the anæsthetic, but believed it depended upon the uræmia, as he had repeatedly noted a similar depression in advanced stages of Bright's disease. The urine had been examined several times and nothing found to indicate disease of the kidneys; in fact, there was not a single symptom present to excite suspicion of trouble in these organs, except the constant inclination to micturate, for which the prolapsed bladder was sufficient to account.

Dr. Parish presented the

Specimen of a Strangulated Ovarian Cyst,

and said: The patient was not aware that anything ailed her until one night she was seized with intense abdominal pain, and, jumping out of bed, rushed about the house screaming with her suffering. Dr. J. H. Musser was sent for and gave her a hypodermic injection of morphia. The dose had to be repeated frequently, and in two days the pain began to subside, it being altogether gone in five days. The temperature remained nearly normal until the fourth day, when it was found to be 103°, and was the same on the next day, the day of operation. A notable fact is that the temperature and pulse both rose steadily while the pain as steadily decreased after the third day. I saw her on the fourth day and agreed with Dr. Musser that we had an ovarian tumor with a twisted pedicle to deal with. Because of the absence of the husband, the operation was not performed until the next day, Jan. 17, 1888. The tumor was found to spring from the left ovary, and was very black, in this respect differing entirely from an ordinary ovarian cyst. The contents were those of an ordinary cyst with coagulated blood in addition. The pedicle was twisted three times and was quite soft and black. After emptying the tumor he untwisted the pedicle and transfixed it below the point of twist, and the tumor was removed. The recovery was very rapid, the temperature, going down steadily. The drainage-tube was removed on the second day. The patient is now entirely well.

Twisting of the pedicle is a well recognized accident to ovarian tumors, but the cases do not all present such marked changes as this case did. The specimen as it lay on the plate presented a very marked contrast to the cyst lying beside it, and which had been removed a few days before from the broad ligament.

In connection with this case he would report one operated on three months ago. The woman had complained of sudden intense pain in the pelvis, and was confined to her bed from that moment. She had remained in bed for over two months with general peritonitis. A number of physicians had attended her, and one of them had introduced an exploring needle into the abdomen. She was extremely exhausted, and had a constant temperature of 103° or higher. An incision was made above Poupart's ligament and opened into a tumor. It was found to contain pus and coagulated blood. Its cavity was cleansed out and the incision closed around a drainage-tube. The cyst walls were very thick. It was a blood cyst; but it could not be determined at the time with certainty whether it was intra- or extra-peritoneal, but it was believed to be intra-peritoneal. In three days strangulation of the bowels developed with fæcal vomiting. The bowels could not be gotten open and a second operation was proposed on the next day, but was refused by the friends. On the day after, however, a second incision was made from a point under the spleen towards the old incision above Poupart's ligament. There was a distension of the abdominal walls in the right lumbar and hypochondriac regions. Great pain under the spleen had developed. The intestines were found adherent in a mass, and three large bands were found to extend from the region of the spleen to the right inguinal region. The adhesions were broken up, and these bands were ligated and cut off. No irrigation was used. The whole wound was closed and a large piece of adhesive plaster was placed over it to protect it from the discharges from the lower and first incision. Convalescence was a slow one, but had finally terminated satisfactorily.

—The *Medical Record*, April 21, states that the Essex County Medical Society has begun a war upon the physicians practising in Newark, N. J., who have not proper diplomas to practice, and the Committee on Illicit Practice has been directed to secure the indictment by the Grand Jury of three persons who have, it is alleged, no legal status as physicians.

NEW YORK ACADEMY OF MEDICINE.

Stated Meeting, April 5, 1888.

The President, A. Jacobi, M.D., in the Chair.

A Contribution to the Diagnosis and Surgery of Cerebral Tumor.

Dr. E. C. Seguin and R. F. Weir made the contribution.

The first part was devoted to the description of a case. The patient was a resident of Bridgeport, thirty-nine years old, who in 1882, when he had malarial fever, with a good deal of pain in his head. His wife one day noticed spasm of the right cheek and neck. This was the "signal symptom." Consciousness was not lost. He had one or two similar attacks up to 1885, but the man's wife felt sure that there had been no spasm extending down to the right arm or hand until that year. In 1885 the symptoms of cerebral disease became more marked. One day that year he fell, became unconscious, bit his tongue, and probably had a general convulsion. He had had similar attacks at long intervals since. These epileptic attacks were preceded by an aura. There was no history of epilepsy earlier in life, nor of syphilis. The epileptic attacks were always preceded by twitching and jerking in the right face, arm and hand. The patient was brought to Dr. Seguin in August, 1887. Memory was not as good as formerly; speech had become thick; the general health was good. After this date the symptoms grew rapidly worse until the operation, November 17, 1887. He felt a numb and heavy sensation in the right upper extremity. The tongue was tremulous, and projected a trifle to the right. Paresis in the right arm and hand grew more pronounced, until the strength was about two-thirds that of the left. After the patient was first seen by Dr. Seguin, a local pain developed over the motor zone on the left side. The symptoms did not extend downward, nor to the left side. Two days before the operation the temperature over the scalp was carefully tested, but the result of the examination was considered negative. The diagnosis of a tumor in the motor zone on the left side was made. They were uncertain whether it was cortical or subcortical. The saliva escaped from the right buccal angle. There was some loss of muscular sense in the right hand. The eyes were normal.

Dr. Weir performed the operation November 17, making the center of the opening the

auriculo-bregmatic line and the middle of the motor zone on the left side. The trephine was used at two places, and the opening being joined, the dura mater was exposed a distance of two by three inches. At first no abnormal condition could be discovered; but afterwards, when deep pressure was made, a resisting body was felt, which proved to be an infiltrating sarcoma of the size of an almond. Brain substance of the size of a pea was all that was lost. The patient left the hospital for home one month after the operation. His symptoms since then have varied, being worse when he was suffering from malarial or intermittent fever. There was almost complete right-sided hemiplegia and aphasia just after the operation; it was nearly a month before he had another convulsion. The patient's condition differed little at present from what it had been before the operation, but Dr. Seguin felt convinced that there had been improvement in sensibility, both of the face and hands, while the wife said the twitching in the muscles of the face had ceased. The aphasia was about as it was before the operation. The mental symptoms did not show any increased intracranial pressure or relapse of the sarcomatous growth. Dr. Seguin thought the tumor, although situated about an inch below the surface of the brain, might have involved to some extent the cortical substance of a deep convolution in that neighborhood. He thought the operation had prolonged the patient's life.

The remaining part of Dr. Seguin's contribution was an application of present knowledge to the diagnosis of cerebral tumors, especially of cases suitable for surgical interference, while Dr. Weir reviewed cases operated upon. Dr. Keen, of Philadelphia, then gave a part of the history of a case of large cerebral tumor removed by him last fall. The patient still survived.

—The *Phar. Record*, April 1, 1888, states that soapstone incorporated with oil, after the manner of a paint, is said to be superior to any kind of paint as a preservative. Soapstone is to be had in an exceedingly fine powder, mixes readily with prepared oils for paint use, covers well surfaces of iron, steel or stone, and is an effectual remedy against rust. It has been known to protect some stone work, such as obelisks, in China for ages past. The writer who calls attention to this is a scientific expert of London, who has noticed the use of this Chinese soapstone in China, and has been experimenting with it since his return to England.

Foreign Correspondence.

NEWS FROM PARIS.

Recurrence of Cancer.

At the meeting of the French Congress of Surgeons, M. Cazin showed the result of his practice from 1862 to 1886, in reference to the recurrence after operation of cancers of the breast. He attributes the comparatively considerable proportion of his successes to the course of treatment he has always followed, namely, very thorough removal, even when the glands are quite healthy. M. Verneuil said, "Besides the operative precautions so well described by M. Cazin, the means to be employed to prevent the recurrence of cancer are still the subject of study. What have we as a preventive against these complaints? As a rule, a six months' treatment after the operation is the only thing recommended. Nevertheless, I think that these germs, in the embryonal state, may be destroyed or attenuated by medication, which is inapplicable in cases of declared cancer. I recommend, after the operation, a permanent arsenical and alkaline treatment, say $\frac{1}{20}$ grain of arsenic per diem and a teaspoonful of magnesia in a glass of cold water every night, in connection with an entirely vegetable diet. I am aware that M. Reclus is on the point of publishing some important papers on this question; and must admit that cancerous affections are greatly on the increase. It is well known, that since the rural population have taken to eating meat more generally, tuberculosis and arthrites, which foster cancerous growths, have been on the increase." M. Poncet said: "Looking to the whole of the facts brought under observation, he concluded that: 1. Relapse is nearly always fatal in subjects presenting a direct cancerous heredity; 2. When the glands are attacked, the tendency to relapse increases; 3. The best hope of a cure lies in a rapid and thorough ablation. In certain regions no hesitation should be felt in carrying out the preliminary operations, although these might seem out of proportion to the size of the tumor to be removed. 4. It is, however, desirable to abstain from attempting any radical operation under too unfavorable circumstances; numerous cases justify only palliative action." M. Labbé, of Paris, said it was difficult to give an opinion on the question based upon authentic figures, but the opinion of an experienced surgeon might be of some weight. The necessity of com-

plete local and glandular ablations was generally admitted in surgery; yet patients, as a rule, do not readily consent to the removal of a limb to all appearance but little diseased. "A dermoid tumor of the breast, the recurrent tendency of which I pointed out to M. Coyne, is an interesting study. In this, a bare enucleation is notoriously insufficient; it is necessary to go far beyond the enveloping capsule. Furthermore, when such tumors have taken considerable extension, the entire breast has to be removed; and then the remainder of the gland, which is pressed back eccentrically and flattened, has to be sought for; and it is hard to find, as I recently demonstrated to some young surgeons at the hospital. By taking this precaution, the six or seven successive regrowths, in this rather mild form of tumor of the breast, are prevented. I will say a word on immediate auto-plastic surgery, of which I am a warm partisan, especially where the face is concerned, as there ablations, as extensive as required, may be effected. A case I have had under treatment for the past six years, that of a man, from whose face I removed the entire cheek on one side, together with the submaxillary glands, has been attended with perfect success. In partial epithelioma of the face, the application of Côme Bros. *caustic balm* is to be preferred to the bistoury. Finally, I entirely concur with M. Verneuil as to the indefinite treatment to be followed after the operation; and I furthermore recommend the application of Nussbaum's tincture of condurango."

M. G. Richelot stated that, according to statistics, vaginal hysterectomy was followed by more relapses than even epi-vaginal amputation of the neck. This was to be explained by the fact that many surgeons of the present day had advocated partial operation in limited uterine cancer, and only proceeded to hysterectomy in such cases as were not to be operated on without it. He suggested, as a means of diminishing the chances of a relapse, the resection of a strip of the vagina, useful more especially in epithelioma of *cauliflower* or tench-head growth, which has more tendency to propagate on the side of the vagina than on that of the uterus. Respecting incomplete operations upon the uterus, he added that these should only be attempted as a last resort, where the diagnosis was incomplete, and that they should not be performed where it was found that the broad ligaments were attacked. M. Castex, of Paris, recalled a case, followed by post-mortem examination, in which propagation of sarcoma through the blood-vessels was traceable in the cartilage of the knee. A sarcomatous colony, connected with the degenerated synovial membrane by vessels of fresh growth, existed in the middle of the cartilage, which was otherwise healthy. M. Sabatier, of Lyons, believed that, to avoid local recurrences, it was necessary to remove the malignant tumors intact, as true cancerous grafts easily formed on a fresh wound. The danger was all the greater in a primary reunion, which favored the development of these germs; these, on the contrary, were eliminated with the discharges of suppuration in cases of secondary reunion.

M. Mollière, of Lyons, said that in cases of recurrent cancer, the age of the patient had to be taken into account. In children, recurrence was so rapid that serious operations could not be justified. In a woman of 30, a recurrent cancer in the breast was exceedingly dangerous; chances of survival were greatest at 50; and after 70 it might be said that cancer caused no headway.

Speaking of

Ocular Epithelioma and Melanosarcoma and their Recurrence.

Dr. Galezowski, of Paris, said: Malignant tumors of the ocular globe develop more especially in the anterior segment of the eye, a fact explained by the greater nutritive activity existing on the level of the sclero-corneal border. In these tumors the epitheliomata do not appear to be reproduced through the channel of the blood and lymphatic vessels, as they would then be confined to the affected spot from the very first. Like M. Verneuil, I have observed that in the eye, as in many other parts, neoplasms of a malignant type are of far greater frequency than they were twenty-five or thirty years ago. It is, however, easier nowadays to remove such tumors; but it is often difficult to discover the precise spot at which the evil has taken root. In any case, melanotic epithelioma invariably becomes implanted on the edge of the cornea.

Abdominal and Vaginal Hysterectomy for Cancer.

M. Demons, of Bordeaux, stated as his opinion that hysterectomy for cancer is only called for in cases of defined cancer of the uterine body. The lowering of the neck of the uterus is sometimes very difficult when the neck is friable; but newly-invented instruments may now be used in taking a firm fulcrum on the body, as the Museux forceps are inadequate for this. As to the checking

of hemorrhage, a most important question, he did not hold with M. Richelot, who, at the last Congress recommended systematic application on the broad ligaments of the forceps invented by Dr. Péan. It is most difficult to fix the forceps when the uterus cannot be brought down sufficiently. Besides, the forceps do not always prevent the first hemorrhage; and, finally, they have the disadvantage of causing the broad ligaments to slough, retarding the healing process, and determining the elimination of dead tissue, attended with a certain rise in temperature. It has also happened that the ureter and wall of the rectum have been seized by the forceps. The use of forceps may, however, be recommended in special cases.

Dr. Péan informed the Congress that his operations of total vaginal hysterectomy were prior to those of Dr. Demons. Dr. Péan proceeded to say: "Those of my colleagues who contented themselves with following my example in buying ready-made instruments of the maker, should also have attended to the temporary nipping and not exclusively to the definitive action, as the former alone enabled the uterus to be quickly removed without loss of blood. It also enabled the operator, after the ablation of the organ, to draw and bring down the broad ligaments, and if necessary, to take them up in two halves; and this without difficulty or fear of hemorrhage. Furthermore, by its use, ligatures may be dispensed with entirely, if it is sought to make the operation a final one, by leaving the forceps fixed at the spot. Experience has taught me that the reverse of what M. Demons recommends must be done, and that it is when the uterus is small, loosened and easy of removal that ligature should be had recourse to."

M. Terrier found vaginal hysterectomy a difficult operation when he had recourse to ligatures; and, on the contrary, very easy by the fixed forceps method. It was a serious operation, inasmuch as it gave a death-rate of twenty-two per cent. of the cases operated on; it appeared, however, more rational than partial amputation, although this was easier and not originally so dangerous. "I have had seventy per cent. of these cases of relapse under my observation," M. Terrier said, "and effected a cure in thirty per cent. of the cases. To establish the superiority of partial ablation over hysterectomy, statistics relative to the former, drawn up under the same conditions as our own, should be forthcoming; but whatever may be said, such data do not exist."

M. Richelot upheld the fixed forceps method. True, it was difficult of application when the uterus did not descend properly; yet it was in such cases that it was most useful, as ligature under the circumstances was impossible. "I do not believe it retards cure," said M. Richelot; "the only dangerous period is the two days during which the forceps are allowed to remain fixed to the spot; on the third, the peritoneum is closed, as I have ascertained in two *post-mortem* examinations. The patients entirely recover within a week, and may get up in three weeks. I believe that the operation has become so common in France for the past two years owing to the systematic use of the fixed forceps; and the large number of instruments sold by the makers is an evidence of the fact. Abroad even, the forceps are used by Müller, and Landau advocated them at the Congress of German Surgeons."

M. Pozzi maintained that hysterectomy had became an operation sufficiently harmless to be legitimately carried out in all cases previously reserved for vaginal amputations of the neck.

Orthopædic Apparatus.

M. Redard, of Paris, referring to the constructions of orthopædic stays, stated that the best, after all, were those of simple form made by the surgeon. In plastered corsets suspension should be gradual and slow; the patient should be prepared for it several days in advance, and it should never be complete as the the tips of the toes should not leave the ground. If the collar is exactly fitted to the neck and chin, no accidents need be feared. The trunk should be covered with a thin undershirt of elastic material, provided with removable braces, and twice the length of the corset, the lower half of which it should overlap. Salient parts should be covered with strips of white felt. The corset should be made removable in all cases of scoliosis. This apparatus is very light, elastic and durable. For silicated corsets a soft metallic cloth is used with meshes (.156 inch) to be covered by silicated bandages.

The Fourth Congress of French Surgeons will open in Paris on the first Monday in October, 1889, under the Presidency of Baron Larrey, Prof. F. Guyon being Vice-President.

—The new Iowa liquor law requires pharmacists to have a permit authorizing them to administer oaths, and each purchaser must swear that he wants the liquor for lawful use.

Periscope.

Treatment of Colds and Bronchitis.

In the *Therapeutic Gazette*, April 16, 1888, Dr. H. C. Wood discusses in a leading article the treatment of colds and bronchitis. When the cold is a widespread general one, involving the whole body in a condition which he regards as a form of subacute rheumatism, with aching pains and general wretchedness, he advises a free jaborandi sweat, followed by a few full doses of quinine. This, he says, will often liberate the sufferer at once, especially if the sweats are aided by mercurial or other purgation. For coryza, he says bismuth and cocaine injections into the nose almost invariably bring relief, though a vigorous dry shampoo may effect the same result.

In bronchitis, he says, the so-called expectorant remedies are of course indicated. These he divides into three groups: First, the narcotic expectorants, which are to be employed to allay excessive cough and quiet nervous irritability; second, the sedative expectorants, to be used in the first stages of a bronchitis, to facilitate secretion and expectoration; third, the stimulating expectorants, useful in the advanced stages of a bronchitis when expectoration has already become free.

The ordinary narcotics, such as morphine and hyoscyamus, and the advantages and difficulties attending their use, he thinks are well known. Chloroform, however, he regards as one of the most valuable remedies that we have for quieting cough. In nervous or hysterical men or women, often the best expectorant mixture is one composed of pure narcotics. A very good home-made mixture for this purpose is one containing:

℞ Whiskey,
Paregoric,
Glycerine, of each.....f℥ij
Chloroform.....♏ xxx
M. Shake well before using, and take in teaspoonful doses *pro re nata*.

This mixture has, he says, enabled patients to secure many a night's rest, by keeping a little bottle of it, tightly corked, at the bedside, and sipping it when necessary.

With regard to the use of hydrocyanic acid as a sedative, he seems to think that its action is so fugacious as to be untrustworthy in ordinary safe doses; while wild-cherry bark preparations he rejects as certainly useless.

The older depressing expectorants he thinks have little power, unless given in nauseating doses, and in their stead he has come to use very largely the citrate of potassium. Of the following prescription, he says that he thinks any one who will use it will never give it up, unless some new remedy of greater power be discovered:

℞ Potass. citrat.....℥j
Succi limonis.....f℥iss
Syr. ipecac.....f℥ss
Tr. opii camph.....f℥iij
Syrupi q. s., ad.....f℥iij
M. Sig.—Dessertspoonful every two hours.

This dose is for a robust man, and must be varied according to the strength and peculiarities of the individual patient.

Of the older stimulating expectorants the only ones in which he still places confidence are the muriate of ammonium and the syrup of garlic. When the citrate of potassium mixture fails, he habitually resorts to the muriate of ammonium, and has often seen very good results from its use. It may be given in capsules if the stomach is very sensitive, each capsule to be followed by a drink of water. The following furnishes the best disguise for the taste of the drug that he has been able to concoct:

℞ Ammonii chloridi,
Ext. glycyrrhizæ.....āā. ℥iss
Glycerini.....f℥ss
Mucil. acaciæ.....f℥ij
Syrupi,
Aquæ, q. s. ad.....f℥iij
M. Sig.—Dessertspoonful every two hours.

Syrup of garlic is so disagreeable to most patients that it is very rarely used. In his own practice, in ordinary cases, the only stimulant expectorants used besides the muriate of ammonium, are oil of eucalyptus, terebene, and oil of sandalwood, and occasionally oil of cubebs or copaiba. The doses of these remedies are so small, he says, and the taste of most of them so disagreeable, that they should always be administered in capsules. The oil of eucalyptus he is inclined to regard as the most efficient. It may be administered in an ordinary cold or a bronchitis so soon as free secretion has been obtained. Terebene is a little more stimulating than the oil of eucalyptus, and to be employed somewhat later in the disorder (dose five minims). The oil of sandalwood is about equivalent to terebene, while the oil of cubebs is employed still later in the disorder.

Indications and Contraindications of Antipyrin.

At the meeting of the Therapeutic Society of Paris, February 22, 1888, M. Huchard referred to the investigations of Robin and

Casimir, which indicate that antipyrin diminishes the quantity of urine, and expressed the opinion that on this account the drug was contraindicated in certain affections of the kidneys. If it is of use in pure nervous angina pectoris, it is inactive in true angina with stenosis of the coronary arteries. If the heart's action is intermittent, its use may result in weakness of the heart and collapse. In two cases of broncho-pneumonia, Huchard observed grave collapse following moderate doses of antipyrin.

On the other hand, he recommends it in polyuria, on account of its capacity to diminish the quantity of urine. He had under his care a woman thirty-eight years old, who had suffered since her eighteenth year with a meningo-myelitis which followed typhus fever. For several months she drank a great deal and passed as much as 48–56 pints (24–28 litres), of urine a day. The reflexes were heightened, there were violent pains in the limbs and along the spinal column. In order to act upon the nervous system and upon the polyuria, Huchard gave two drachms of antipyrin daily. The quantity of urine diminished in ten days to 10 pints (5 litres) in twenty-four hours. The antipyrin was then stopped, and at once the quantity of urine increased, although not to the same height as before. Up to the present time Huchard has treated only one case of polyuria in this way, but he refers to the fact that Dr. Göllner had obtained improvement in a few days in a diabetic patient through the use of large doses of antipyrin. Huchard holds that antipyrin is proper only in nervous polyuria, while in the polyuria accompanying nephritis, he obtained no result. — *Deutsche Medizinal-Zeitung*, March 26, 1888.

Massage in Alcoholic Asthenia.

Dr. James Barr, physician to the Northern Hospital, Liverpool, in the course of his lectures upon alcoholic asthenia (*Lancet*, January 14 and 21, 1888), remarks upon the efficacy of massage in the treatment of this condition. The muscles, he says, are the great furnaces of the body; in them oxygenation largely takes place, and the effete materials are burned off. It has been truly said that a man digests with his muscles as well as with his stomach; so when we have active muscular exercise the appetite is improved, a greater amount of nutriment is taken in, and tissue change goes on more rapidly. Life implies change; without tissue metamorphosis there could be no life. Some people manage to exist with a small income and equally small expenditure; but their life is that of a sloth; it is mere existence, a sufficient amount of energy to hold the molecules of their composition together, without anything worthy of the name of life. When one wants to restore lost energy he must increase the force, but in order to do so there is no use in supplying the fuel without the fire to light it. There is no use in putting nutrients in the patient's stomach unless he is able to assimilate them. If the muscles are run down and there is no spare nerve energy to make them work, then the places of the nerve current must be supplied by massage and electricity. Massage is a most powerful agent for effecting nutritional changes, and with the increased combustion and greater supply of food, not merely the muscles but also the heart and every organ of the body is nourished, and nerve energy is stored up for future use. He says he has seen a pulse which would not even move the weight of the lever of the sphygmograph, give an excellent tracing with a pressure of five ounces after eight weeks' massage.

What Constitutes a Stone in the Bladder?

In the *British Medical Journal*, Feb. 18, 1888, Sir Henry Thompson takes occasion to state his opinions as to what weight of concretion in the bladder merits the name "stone." The occasion of his communication on this subject is the recent publication of "A Hundred Cases of Stone in the Bladder," by Surgeon-Major O. J. Freyer. With reference to this paper, Sir Henry says: "Among the hundred cases of stone thus reported, I observe no fewer than a dozen cases, the largest of which does not exceed twelve grains, and this not merely in children, for ten of them are adults. But what is more remarkable still, is that a tiny concretion weighing only two grains is twice reported as 'a stone' in the adult bladder, as are also two of three grains each, besides others of four and five grains respectively. Indeed, the total weight of the 'stones in the bladder' for which in eight adult cases 'the operation of lithotrity' has been performed amounts to no more than thirty-seven grains, an average of about four grains each, the total weight of the eight being only that of quite a small stone." Such tiny products, he says, are easily removed for the most part by washing out the bladder, from which, indeed, they usually escape spontaneously. Personally, he never reports a case as one of stone in which the weight of the concretion is less than twenty grains.

Rare Anomaly of the Hymen.

In the *Archiv für pathol. Anat.*, Bd. cxi, Heft 2, p. 386, Feb. 1888, Dr. S. Krysinski, of Dorpat, states that on examining a girl who was suffering from leucorrhœa and some disturbance of the menstrual function, he found an anomaly of the hymen which, as far as he knows, has been hitherto undescribed: It appears that the hymen was pretty thick and round, and that in its left inferior portion there was an opening with an irregular border, which scarcely permitted the passage of a sound 5 mm. (.195 inch) in diameter. In the median line and above this opening there was a projection about twice the size of the latter, which at first glance was taken for the orifice of the urethra. A more accurate examination, however, disclosed the fact that this projection was formed by a duplicature of the mucous membrane of the hymen; in appearance it was not unlike the semilunar valve of the aorta. But from the middle of the free border of the valve anteriorly, it was nearly slit in half. Neither in the inferior nor lateral borders, nor in the posterior surface of the little pocket formed by it, was there an opening present; so that the pocket formed a blind sack, completely shut off, and diminishing in size toward the bottom. The urethra, so far as an examination by means of the sound could determine, opened about one or one and a quarter inches behind the hymen, into the vagina. The urine was passed through the opening in the hymen; but how much this circumstance may contribute toward the development and obstinate persistence of the leucorrhœa, the author says he must leave undecided.

United Fracture of Tooth-Fangs.

Dr. Williamson exhibited recently to the Odonto-Chirurgical Society of Scotland, an interesting case of fracture of the root of a central incisor, which bore evidence of having been united. There was a history of a blow in childhood, from which the right incisor received so much injury that its pulp died, as was shown by its discolored appearance. But both teeth had done good service until the patient reached the age of 45, when the left central became so loose that it was removed with the fingers. A part of the fang, however, was left behind; but, being loose, was easily extracted. On examination, it was found that the two fragments fitted accurately when placed in opposition, except where there was a little chipping at one edge. The fracture of the dentine was at a higher level than that of the cementum, so that the latter formed a sort of collar for the lower fragment. There was some thickening in parts of the cementum, and the whole of the pulp in the coronal fragment was calcified and also the part close to the line of fracture in the other piece.—*Lancet*, Feb. 25, 1888.

Climate and Distribution of Cancer.

In concluding a series of papers on the geographical distribution of cancerous diseases in the British Isles, A. H. Haviland says (*Lancet*, March 10, 1888): "I maintain that those who would give themselves the best chance of avoiding those local conditions which are coincident with a high death-rate from cancer should study well the distribution of this disease in England. There is abundant evidence there to show that cancer does not thrive in high, dry localities, where the soil is kept sweet by the absence of floods, and the nature of the rocks which either underlie it or form its principal constituents; and that it does thrive and become very fatal where floods prevail, where their emanations are sheltered and intensified, where vegetation is killed and decomposed, and where, after the floods have passed away, a rank herbage springs up, composed of sour grass and bitter plants, which scour and otherwise disease the horses, cattle and sheep that feed upon them. Much has to be done, much has been pointed out, and if the twenty-two high mortality and the sixteen low mortality districts were well studied in connection with the various factors which we have seen to be coincident with high or low death-rates, I believe that much would be added, much would be corrected, and much revealed that we little think of now."

The Catgut Suture.

M. Monod, at a meeting of the Société de Chirurgie, spoke on the accidents attending the use of certain kinds of catgut, and cited the case of a Swiss surgeon who had a regular series of accidents—phlegmons, erysipelas, gangrene. He substituted for the catgut carbolized silk, and ever afterwards had union by first intention even in major operations. M. Lucas said that the catgut of commerce should be abolished completely from the treatment of wounds. The carbolized silk was much superior, especially in the ligature of the pedicle of an ovarian cyst. The ends, instead of being eliminated, became encysted without causing any prejudice to the patient. —*Medical Press and Circular*, February 8, 1888.

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TREATMENT OF TYPHOID FEVER.

In an excellent clinic at the Hôpital Necker, in Paris, Prof. Peter recently gave a summary of his views in regard to what he calls typhoid fevers; meaning by this term the different varieties of what is known by the general name of typhoid fever. In this lecture, which is reported in the *Bulletin Médical*, March 25, 1888, Dr. Peter speaks of the change which has taken place in the type of typhoid fever since he first studied it in the days of Chomel and Louis. He rarely sees now, he says, the greatly distended abdomens, the baked tongues, the discharging and excoriated nostrils, the violent delirium and agitation which he formerly saw so often. This fact he attributes partly to the improvement in the hygienic condition of Paris, and the improved sanitary condition of its inhabitants. It is partly due, however, to the modifications which have taken place in the principles governing the treatment of typhoid fever, and the recognition of the fact that its different varieties demand different methods of treatment. He does not commit himself to the microbe theory of the disease or to the theory that it is caused by a ptomaïne or a leucomaïne; he devotes his attention principally to the subject of the fever, and studies what conditions in the latter influence the natural history of the disease, and determine the proper method for conducting the patient safely through it.

His views are so thoroughly in accord with the opinions expressed in an editorial in the REPORTER, December 3, 1887, that we call the attention of our readers to them. Prof. Peter points to the power which the animal organism has to cast out the infecting material which disturbs its functions, and the duty of the physician to abstain from interference so long as this process goes on with reasonable rapidity and success. Bearing this in mind, he warns against any ill-timed effort to restrain the natural attempts at elimination of the poison of typhoid fever, and commends an attitude of expectancy so long as no grave accident of the disease demands active interference.

The conditions which justify non-interference are a reasonably moist tongue, an abdomen in which there is no extreme distension, a skin which is open and naturally moist, and a pulse not much over a hundred. As to temperature, Prof. Peter expresses little concern, and plainly intimates that he does not share the general opinion that its variations indicate the varying gravity of the patient's condition. The line of treatment proper to most cases, he says, is clearly determined by the instinct of the patient: rest is called for by his weariness and exhaustion; diet by his want of appetite; free supplies of water by his thirst; moderate stimulation by his weakness. To meet these instinctive demands, he advises rest in bed, milk food, and lemonade, to which moderate quantities of wine are added. The latter supplies at once three important agents: water, an acid, and a stimulant. Of specific medication he recommends only an occasional saline laxative in the shape of a glass of some aperient water—he says Seidlitz-water, which must not be confounded with the artificial water made with a Seidlitz-powder—and a cool enema, or lavement. Quinine he gives only occa-

sionally, and in small doses, using it solely as a nerve-tonic.

The tenor of Prof. Peter's opinions might be misunderstood, did he not plainly state that he recognizes the fact that there are cases of typhoid fever which demand more energetic treatment; but he states as well that the majority of the cases are amenable to such an expectant method as is outlined above. And he adds that this would be decidedly preferable, as a routine method to the routine application of any of the recognized systematic methods.

The eminence of Prof. Peter as a practitioner and as a teacher and his great experience give unusual weight to his opinions; and those who hold similar opinions may rather be gratified and encouraged than hope to offer any support to them. For this reason we lay his mature and well-digested conclusions before our readers, believing that a careful study of them cannot fail to have a useful influence in guiding any thoughtful medical man to the right way to treat so common a disorder as typhoid fever.

TREATMENT OF PUERPERAL MASTITIS.

In few diseases can more be done, in the way of prevention, than in mastitis. Hence a recognition of its causes is important. Much stress was formerly laid on the influence of draughts of air, mental depression, obstruction of the milk ducts, and so on. The influence of these causes must be remote. Accurate observation has established a frequent causal relation between nipple lesions—ulcers, erosions and fissures—and mastitis. Billroth lays stress upon these lesions, as affording the route of entrance to germs, but he questions the occurrence of infection along the milk ducts. Bumm, who has recently studied the subject, admits both methods of infection, and claims a different course for the affection in each: that infection through surface lesions leads to acute abscess, with only secondary involvement of the lobules, while infection from within the ducts of the glands causes parenchymatous mastitis, beginning as an inflammatory hardening of one or more lobules, and leads to purulent infiltration of the periglandular tissue. As the abscess develops these differential points become confused or lost. Primiparity, and the imperfect establishment of lactation are recognized as factors, and are well known causes of nipple lesions. Prolonged lactation also favors mastitis and abscess. Here debility on the part of the mother, and more especially traumatism inflicted by the infant's teeth, are to be considered. Fordyce Barker and others have called attention to the frequency of mastitis during the prevalence of puerperal septicæmia, distinct from pyæmic abscesses occurring in this situation. Roser pointed out that retention of milk, so long regarded as a cause, is but a result of the process, being brought about by occlusion of some of the excretory ducts from inflammatory swelling. Most obstetricians are now inclined to this view, and regard puerperal mastitis as being in direct relationship to disease of the nipples.

Hence prophylactic measures should be directed toward the preparation of the nipples during pregnancy for lactation, and early recognition and cure of nipple lesions, with the prevention of infection during their course.

The essential element in the successful treatment of mastitis is rest, physiological and physical. Especial attention was called to this by Harris, of New Jersey, in a valuable paper in *Amer. Journ. of Obstetrics*, January, 1885. Nursing from the affected breast should be stopped. The only exception to this rule is in cases of trivial sub-dermal inflammation or abscess; and here lactation should not be allowed if painful. Physical rest is best obtained by the use of the roller bandage. The inflamed breast (or both, if the affection be bi-lateral) should be enveloped in a moderately thick layer of cotton batting, or sheep's wool, and a figure-of-eight bandage firmly, smoothly, and not too tightly applied. The object is to support, immobilize, and slightly compress the breast. A well applied bandage will always give comfort. A roller two and a half or three inches wide and fifteen yards long will be required. The shoulder and axilla may be protected by a

layer of cotton. Wool is to be preferred, owing to its greater resiliency. The bandage may be changed daily, or on alternate days. Other local measures are not called for. Active manipulations, such as stroking, or the use of the breast-pump, should be forbidden; not only because they are founded on a false pathology, but more especially because they add to the mother's pain, and favor suppuration through increased afflux of blood.

By constitutional measures, much can be done to favor resolution and give comfort. The patient should be strictly confined to bed through the active stage. Quinine in doses of from fifteen to twenty-five grains daily, given in two or three doses, unquestionably modifies the inflammation. A brisk purge of the citrate or sulphate of magnesia, given in the beginning and repeated on the second day, relieves vascular tension, and perhaps acts by derivation. Sufficient morphia, or Dover's powder, and the bromides should be given to relieve pain and allay nervous excitement. This treatment, if instituted early, will bring about resolution in a large majority of cases.

When suppuration occurs, the pus should be evacuated early, before it can burrow. Etherization is usually necessary. The incision should be radial, and one-half inch in length. Strict asepsis should be maintained. Where the abscess is large the drainage-tube should be inserted. Insufficient punctures cannot be too strongly condemned. The dressing and after-treatment should be conducted on modern surgical principles, and the process of cicatrization will be greatly assisted by well-applied pressure with the bandage.

PRESCRIPTION OF UNOFFICIAL FORMULÆ.

In connection with our editorial in the REPORTER, April 14, 1888, it is interesting to note that the *St. Louis Drug Clerks' Association* has inaugurated a movement to ascertain what unofficial formulæ, or simple drugs or chemicals, are most frequently ordered by physicians in that section of the country. Circulars have been sent out to a large number of druggists with the request that each recipient shall examine his prescription file for the year 1887, and note what drugs or compounds, not included in the U. S. Pharmacopœia, have been ordered and how often each one of them has been prescribed. The object of this investigation is said to be to furnish information which shall be of use to the Revision Committee of the U. S. Pharmacopœia for 1890. This object is deserving of cordial and general support. It is quite possible that the information intended to assist the Revision Committee in its deliberations may prove quite as interesting to the manufacturers of commercial formulæ as to it; but, none the less, we believe it will serve a useful purpose, if a correct statement can be prepared as to the drugs and compounds which are most frequently prescribed. The general use of any one of these may not certainly indicate its value; but it must suggest the propriety of investigating the causes of its popularity, and if these be found to depend upon intrinsic merit the result cannot fail to be of service to the medical profession.

ANTIPYRINE IN LABOR.

At the meeting of the French Academy of Medicine, March 13, 1888, a paper by Dr. Queirel was read, in which he claimed that antipyrine is a valuable drug in labor, as it calms the excitement of the parturient woman and lessens her pain. Its influence is most beneficial in the first stage of labor; and it does not interfere with its progress at all. Dr. Queirel founds his opinion upon an experience of twenty cases, in fifteen of which his results were very satisfactory. He administers the drug by (hypodermic?) injection, in doses of about four grains, giving a second injection in two hours if the first has not produced the desired effect. Usually he found the influence of the antipyrine to be manifest in from twenty to twenty-five minutes; and he compares it to that of chloroform, with the great advantage that it is a much safer agent.

The announcement of this action of antipyrine tends to confirm the growing opinion that it is an admirable nervine, and supports the views of Germain Seé and of Robin in regard to it.

Book Reviews.

[Any book reviewed in these columns may be obtained, upon receipt of price, from the office of the Reporter.]

THE HYGIENE OF THE SKIN, OR THE ART OF PREVENTING SKIN DISEASES. By A. Ravogli. 8vo, pp. 400. Cincinnati: Central Publishing Company, 1888. Price $3.00.

In the work before us the author has endeavored to collate and present facts bearing upon the etiology of the various skin diseases, and to build upon this foundation proper hygienic measures. After briefly considering the anatomy and the physiology of the skin, the various internal and external predisposing and exciting causes are discussed. Heredity is credited with the most important rôle, as the following clause indicates: "We shall now proceed to consider the hereditary origin of skin diseases, and afterwards show that hygiene may altogether do away with this tendency and prevent their development." A result so desirable would indeed be a boon to humanity; but we regretfully state that a careful reading of the volume fails to add materially, if at all, to our present knowledge. In some respects also the author's statements are not only at variance with predominant medical thought, but erroneous. Thus in the following: "I conclude, therefore, that hereditary syphilis is the ordinary cause of lupus serpiginosus." And also, in speaking of the (early) excision of chancres: "* * * we believe that it is the duty of the physician to try this easy and simple operation, which will not only cure the patient, but will preserve his family from the most disgusting disease that weakens and deteriorates our race." The following remarkable statement in regard to the macular syphiloderm in the hereditary disease may be quoted: "It is never seen on the neck or face."

The illustrations of the anatomy of the skin, and of the parasites, with one or two exceptions, are from Duhring's treatise; and yet, strange to say, these appear without one word of credit as to their source.

OBSTETRIC SYNOPSIS. By John S. Stewart, M.D., Demonstrator of Obstetrics, Medico-Chirurgical College, etc. 12mo, pp. 202. Illustrated. Philadelphia: F. A. Davis, 1888. Price $1.25.

This book, as we are informed in an introductory note by Prof. Wm. A. Stewart, of the Medico-Chirurgical College, is specially intended for the undergraduate student. It has the advantages and disadvantages of its class. The principal aim of the author being condensation, objects other than correctness of statement are necessarily neglected. Under the circumstances, excepting the section on anatomy, the style is all that can be expected. The scientific basis of obstetrics is very lightly dwelt upon, and often does not appear. The sections on treatment are less condensed; but the dogmatic method of statement is used, which appeals to the memory of the student, rather than to his understanding. Among other errors of statement we note the following: The length of the uterus is given as 2½–3 in., which measurements are those of its canal. The utero-sacral ligaments are said to connect the uterus with the sacrum; no mention is made of their insertion as high up as the second lumbar vertebra. Hydræmia is defined as "a general œdema caused by an increase in the watery portion of the blood." Among other obstacles to delivery, hydrothorax, ascites, and retention of urine in the fœtus are cited, and the author then advises that for the removal of retained urine the catheter must be used." We fancy the technique would be difficult under the circumstances.

In so condensed a treatise we would expect omissions; but the evils of condensation are somewhat too manifest in the parts devoted to anatomy and the mechanism of labor. No reference is made to the method of suspension in the treatment of asphyxia neonatorum. Under placenta prævia we find no mention of the wonderful results obtained by the Braxton Hicks' method of delivery. Styptics are given the preference over sutures for the arrest of hemorrhage in lacerations of the cervix and vagina. This is not antiseptic surgery. The routine use of vaginal antiseptic injections is recommended, although at present they are generally abandoned in the normal puerperium. Students are advised to renew the dressing of the umbilical cord daily; which is certainly unnecessary.

The treatment recommended is generally good, and the advice upon the management of labor is sound, especially as to the use of ergot and the delivery of the placenta. The print of the book is excellent, and the text unusually free from typographical errors. With the exceptions indicated above, we think the book calculated to be useful in refreshing the memory of the student, already grounded in the subject, in his preparation for examination.

OPHTHALMIC SURGERY. By Robert Brudenell Carter, F.R.C.S., Ophthalmic Surgeon to St. George's Hospital, etc., and William Adams Frost, F.R.C.S., Assistant Ophthalmic Surgeon to St. George's Hospital, etc. Illustrated with a chromo-lithograph and ninety-one engravings. Small 8vo, pp. 554. Philadelphia: Lea Brothers & Co., (no date). Price, $2.25.

This is an excellently written and well illustrated manual of the important subject of which it treats. The different chapters are signed with the initials of that one of the authors who composed each one, a precaution which seems hardly necessary, as in the preface they state that they are in general agreement with regard to all portions of the volume. The shape of the book is handy, and its moderate price brings it within the reach of all medical men.

TRANSACTIONS OF THE MEDICAL ASSOCIATION OF THE STATE OF MISSOURI AT ITS THIRTIETH ANNUAL SESSION, 1887. 8vo, paper, pp. xi, 159. St. Louis: Ev. E. Carreras, Printer.

The activity of the State Medical Association of Missouri may be indicated by the fact that it has managed to hold thirty annual sessions in twenty-eight years. The volume of Transactions before us indicates that this crowding has not hurt it; but that it has managed to dispose of these two intercalated years without betraying any sign of premature senility. There is so much to attract attention in the papers contained in this volume that we can only call attention to one point: namely, the strong plea of the President, Dr. J. W. Jackson, to bring out the members of the profession who do not take an active part in the proceedings of their State Society, which he introduces by a quotation from a recent address of the President of the State Medical Association of Texas, to which we have already referred in the Reporter, April 7, 1888.

This is a matter which concerns all the States so much that we cannot forbear alluding to it again, in the hope that we may stimulate the desire on the part of all the physicians in the country to share in this means of advancing the good of their fellow-practitioners and of their fellow-citizens.

TRANSACTIONS OF THE MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND. Eighty-ninth Annual Session, held at Baltimore, Md., April, 1887. 8vo, paper, pp. 152.

One of the most attractive features of this volume —to an editor—is the instruction given, on the page facing the table of contents, to the authors of papers as to the way in which they should prepare their manuscripts. If these were duly studied and diligently observed by all who write for publication, it would save many grey hairs to editors and committees of publication, not to speak of the poor printers themselves. Another interesting feature in this volume is the report of the Publication Committee, from which we learn that the expense of printing five hundred copies of a volume of two hundred and sixty-four pages and five hundred reprints each of the Annual Address and of the President's Address was only $329.18. This is a very good showing indeed, and the committee may be congratulated upon it.

We have not left ourselves much space in which to speak of the papers in this volume, which are not numerous, but interesting and instructive, one of the best of them being the report of a committee appointed to consider the legal points growing out of an address by a former President, Dr. Quinan, in relation to unlicensed practitioners in Maryland. This report may be commended to the attention of medical men of other States, in all of which questions arise similar to those which it discusses.

Pamphlet Notices.

[Any Reader of the Reporter who desires a copy of a pamphlet noticed in these columns will doubtless secure it by addressing the author with a request *stating where the notice was seen* and enclosing a postage stamp.]

The Clinical Value of the Cardiograph. By Thomas J. Mays, M.D., Philadelphia. From the *Transactions of the College of Physicians of Philadelphia*, Third Series, Vol. X. 9 pp.

Membranous Enteritis, with Reports of Cases. By William A. Edwards, M.D., Philadelphia. From the *Transactions of the College of Physicians of Philadelphia*, Third Series, Vol. X. 21 pp.

Xeroderma Pigmentosum, and its Relation to Malignant New-Growths of the Skin. By R. W. Taylor, M.D., New York. From the New York *Medical Record*, March 10, 1888. 9 pp.

Pneumonia: its Mortality and Treatment. A Statistical and Rational Inquiry. By Henry Hartshorne, M.D., Philadelphia. From the *Transactions of the College of Physicians of Philadelphia*, February 1, 1888. 35 pp.

—Dr. Mays's paper contains a good description of the instrument called the cardiograph, and of its uses as an instrument of precision in the diagnosis of disorders of the heart and great blood-vessels. It is illustrated with very good woodcuts.

—Dr. Edwards has made a careful and thorough study of the subject of membranous enteritis, especially of cases in which the passage of membrane from the bowels is unaccompanied by the usual symptoms of acute or chronic enteritis or entero-colitis. He describes the symptoms, pathology and treatment of this curious disorder, and concludes his pamphlet with a full bibliographical summary of the literature of the subject.

—Dr. Taylor presents in his paper an account of seven cases of xeroderma pigmentosum which have come under his own observation, and a table of forty cases, which make up the whole number noted in medical literature, including his own. He describes the clinical features of the disease, and lays especial stress upon the frequency with which it is followed by the development of malignant new formations. His paper is accompanied by a handsome plate containing six figures.

—Dr. Hartshorne presents in this paper a strong and scholarly argument in favor of the now almost obsolete practice of venesection in acute pneumonia. He demonstrates by a very complete statistical study that the death ratio in pneumonia is apparently greater now than it was when blood-letting was the accepted method in its treatment, and believes that this fact is not a mere coincidence. There is much in this pamphlet deserving of the consideration of thoughtful medical men, some of which has a direct bearing upon the subject discussed, and some of which suggests interesting questions incidental to it.

Dr. Hartshorne's calculations of the proportion of deaths in cases of pneumonia before and since the abandonment of venesection have been carefully and conscientiously prepared; and the conclusion at which he arrives seems to be justified by his premises. If it is not it would be doing good service for some one who is competent to take the subject up and correct the strong impression which Dr. Hartshorne's paper must produce upon those who read it.

Literary Notes and Queries.

[In this column the Reporter will publish short items of literary interest and questions addressed to this Journal or its readers, and answers to them, in regard to any literary matters: books, authors, places and prices of publications, etc.]

—*Harpers' Young Folks* has been before the reading public for some time, and seems to meet with favor. Its contents are usually interesting and often instructive. But it has one serious defect: namely, that it contains stories and pictures calculated to make a very painful impression upon the minds of the young. Some of these stories and pictures are, in our opinion, so dangerous to the imagination—especially as suggesting horrible dreams—that we think no parent should trust a copy in the hands of his children until he has examined it to see that it is not likely to cause nocturnal terrors.

—*America* is the title of a weekly paper published in Chicago, at ten cents a number and three dollars and a half a year. The first number is dated April 7, 1888, and contains sixteen folio pages. The name of the paper indicates one of its objects: that is, the cultivation of distinctively American ideas. The articles in this number are contributed by some of the best known writers in the United States, and are both interesting and instructive.

Correspondence.

Pyelitis and Purulent Meningitis.

Editor Med. and Surg. Reporter:

Sir:—The following case has proved so interesting to me that I think it may prove interesting to other readers of the Reporter.

Case.—O. H., five years old, had suffered intensely for a year from colic, the nature of which was not fully understood before his death. During the last six months of his life frequent micturitions, with great pain in the lumbar region, led to a suspicion of renal calculi, though no blood was passed, and the pain seemed too constant to be caused by the passage of stones. The patient finally died after an acute illness of two weeks, his disease being diagnosticated as meningitis. One week after his burial, the parents became dissatisfied with the treatment which had been adopted, and were anxious to have the, to them, mysterious case unraveled. To this end they besought the attending physicians, Drs. Rodgers and Baldwin, with my assistance, to exhume the body and make a *post-mortem* examination.

Autopsy.—The brain was unusually large; convolutions well developed, with slight accumulation of fluid in the lateral ventricles. The membranes were congested, fibrinous clot in longitudinal sinus; membrane adhering to the anterior lobe of the left hemisphere; and at the base, especially surrounding the pons, were adhesions, pus and broken-down tissue. The heart and lungs were normal. The liver was normal. The gall-bladder was distended with bile, which had stained the surrounding contiguous parts a dark-green color. The stomach and bowels were normal, except the rectum, which was completely blocked with hardened feces. The kidneys showed pus in both pelves; the capsule of the left kidney was adherent and its tissue friable. The right capsule was not adherent, and the kidney was normal in size; but, lying loose in the pelvis was a stone three-quarters of an inch long, one-eighth of an inch wide, and one-quarter of an inch thick, weighing 18 grains. The infundibula and tubules contained many concretions, varying in size from that of a grain of sand to that of a mustard seed. The bladder was elongated, and when distended held two fluid ounces. Its walls were much thickened and its mucous membrane was sloughing.

Evidently the pain from which the child had suffered was due to the stone; but is there a connection between this and the meningeal trouble of which he died?

He always located his pain in the left side; and the stone was in right. Had it been possible to positively diagnosticate the trouble no operation would have been justifiable, as both kidneys were equally involved.

Yours truly, I. N. Trent, M.D.

Losantville, Ind.,
April 9, 1888.

Notes and Comments.

Early Stages in the Life of Tænia Pectinata.

According to *Science*, March 23, 1888, at the annual meeting of the Women's Anthropological Society, held in Washington, March 8, an interesting account was given of the studies of Mr. Cooper Curtice in regard to the tænia pectinata.

Thousands of sheep and lambs perish every winter on the ranches west of the Missouri river. They are not apparently afflicted with any disease. They are weak and lean in the fall, and simply seem to be unable to withstand the severity of the blizzards. The Bureau of Animal Industry of the Agricultural Department, has been engaged in an investigation to ascertain, if possible, the cause of the weakness of the animals that perish, and Mr. Cooper Curtice visited the West in the prosecution of this work. An examination of the viscera of slaughtered sheep and lambs, fat and healthy ones, as well as those that were weak and lean, disclosed the fact that they were almost without exception infected with tape-worms, which were found in the duodenum and gall-duct. In the latter they were frequently so numerous as to close it up, and cause a suspension of its functions.

For the purpose of continuing his studies, Mr. Curtice brought from the West a number of lambs, which were killed at intervals and their viscera examined; and this material having been exhausted, and it being inconvenient and expensive to obtain more, he turned his attention during the past winter to a study of the early stages in the life of the *tænia pectinata* (common unarmed tape-worms of the rabbit). In studying these, Mr. Curtice thinks that he has made some interesting discoveries, which he presented to the Biological Society of Washington at a recent meeting.

The variety examined is found abundantly in nearly all rabbits in this locality. The life-history of the armed tape-worms of man and dogs has long been written; but that of the unarmed species inhabiting our domestic animals, especially cattle and sheep, is as yet

comparatively unknown. As far as has been ascertained, the life-history of the *tænia pectinata* is embraced in two stages. The first covers the development of the ova into the embryo, which is ready to leave the parent *tænia*: the other covers the period of growth from the youngest forms yet found in rabbits to the adult stage. The life of the *tænia* from the time they leave the first rabbit as an embryo, until they are found as young *tænia* in the second rabbit infected, has as yet been unascertained. Among the theories that have been advanced, is one that they pass this stage upon the ground, are eaten by insects, snails, or crustaceans, and that these are then eaten by the rabbits. This, however, is only a theory, as none have ever been found in snails, insects, or crustaceans.

It was Mr. Curtice's good fortune to find a rabbit which had recently been infected with these peculiar parasites, none of which were over three centimetres in length, many of them being less than five millimetres long.

There were more *tænia* in that rabbit than any he had ever seen before—about eighty-five. Among the smaller *tænia* were several specimens that showed the stages of development from non-segmented, armed forms to segmented, unarmed forms. Mr. Curtice showed to the society specimens illustrating the different stages.

The youngest forms detected were not the smallest, but measured about one-half a centimetre in length. They contained in addition to the four suckers, a cup-shaped cavity, in the place of the rostellum. Around the border of this cup-shaped cavity were situated eighty-five or ninety hooks. The older specimens show a similar cavity, with no hooks. Still older ones show no cavity at all. All of these were in the non-segmented stages; but other forms, some of them smaller, were without signs of hooks, and had already begun segmentation.

Mr. Curtice compared these stages with similar stages in *tænia serata*, and said that the youngest stage of the *tænia pectinata* was probably a cysticercoid stage, and not the cysticercal, and that this was indicated by the cup-shaped cavity in the youngest forms of the *tænia pectinata*.

In discussing the classification founded on the presence or absence of hooks, he declared it to be incorrect, since the discovery described above shows that the unarmed species in adult stages are armed in earlier stages.

The speaker exhibited some elegant drawings made by Dr. George Marx, illustrating the embryo as it leaves the parent *tænia*. This embryo is six-hooked, and surrounded by a curious pyriform envelope, to which there is a double prolongation surmounted by a cap of the same substance. The cap has a shredded border, and is believed to be the remnants of a mass which, in an earlier stage, completely surrounded the embryo. This peculiar envelope has been previously noticed in Italy by Perroucito, and in France by Raillet. This stage is similar to that found in *tænia expansa*, the unarmed tapeworm in sheep.

The Alleged Action of "Médecines a Distance."

A large portion of a recent meeting of the Academy of Medicine of Paris, was devoted to reading the report of the commission appointed to examine into the phenomena related by M. Luys six months ago. It is to be hoped that the report will not only put an end to the mystification of which M. Luys has been the victim, but that it may lead other observers in hypnotism to place somewhat less confidence in the veracity of their subjects. When the experiments were performed by M. Luys, with tubes of which he knew the contents, the results were the same as he had announced to the Academy, the symptoms observed in the patients corresponding to what would be expected from the medicines enclosed; but when the same experiments were repeated under proper test conditions, the contents of the numbered tubes being known neither to himself nor to the members of the commission, M. Luys' subjects failed in every instance to exhibit the proper symptoms. In a word, the conclusion of the whole affair is, that M. Luys has been the dupe of an hysterical patient, and that there is absolutely nothing in all the phenomena so sensationally announced last autumn.—*Lancet*, March 17, 1888.

Composition of Moxie Nerve Food.

Francis Wyatt, says the *Medical World*, has analyzed Moxie with the following result: One hundred parts by weight when distilled were found to contain three-fourths per cent. alcohol, and one-fourth per cent. of the essential oils of sassafras, winter-green and anise. The residuum in the report was evaporated to dryness, and contained 7.880 per cent. of extractive matter, consisting of

Sugar	3.810
Glucose	1.250
Sodium carb.	1.070
Sassafras	1.870
Gentian	1.870
Checkerberry	1.870
Quassia amara	1.870

Early Anæsthesia.

There is very little doubt that the Aryan surgeons used some form of local and general anæsthesia. From them came the tendency to use both, which is recorded in early Chinese medical literature. Some traditions of these anæsthetics seem to have been handed down till the time of the Crusades, and to have been revived with the advent of the Renaissance. Boccaccio, for example, says in Decameron, Fourth Day, Novel Ten:—"The physician had a patient who had a bad leg, which was due to a decayed bone. Now, the doctor, supposing that the patient would never be able to bear the pain, ordered a certain water to be distilled that threw a person asleep so long as he judged to be necessary." This practice seems to have died out and become a mere tradition, for Thomas Middleton ("Woman Beware Woman," Act IV, Scene 1, printed in 1657), makes a character say:

"I'll imitate the pities of old surgeons
To this lost limb; who, ere they show their art,
Cast one asleep; then cut the diseased part."

The great revival of anæsthesia which took place late in the first half of the present century, owes its origin to Americans, and there appears no doubt from the results of researches, set on foot by the Chicago Medical Society, that the honor of the discovery of the agent chloroform rightly belongs to Dr. Guthrie, of Sackett's Harbor, N. Y., and not to either Leibig or Soubeiran, who dispute it with him. Chloroform seems to have been used as an anæsthetic in Yale before 1840. Its use was, however, soon discontinued, whether because of the influence of the medical dogmatists who held that pain was salutary, or because of an untoward accident, cannot now be determined.—*Medical Standard*, April, 1888.

The Care of the Nails

Very few people know how to properly care for the nails. In cleaning them, a sharp knife ought never to be employed, but between the ends of the nails and the fingers the space should be filled with soap, and then removed by brushing with the so-called nail brush. Many improperly cut away that part of the flesh which grows over the nail from the bottom; but it should be simply pressed backward, and sufficiently to show the white part, considered by some to be a mark of beauty. If the flesh is adherent to the nail the operation may be facilitated by passing the sharp point of a knife underneath the fold of flesh and separating it from its attachments. With this done, it can be pushed back more readily. Scissors should never be used to cut the nails; that should be done only with a sharp penknife.—*Boston Journal of Health*, April, 1888.

The Income of Edinburgh Professors.

The Edinburgh correspondent of the *Chemist and Druggist*, March 24, 1888, says that the incomes of the medical professors of the University are notoriously large. Not only is the medical school the most popular and largest attended one in the kingdom, but the chairs are richly endowed. The total income of the chairs in the medical faculty is £26,628 (about $129,150), the expenses in connection therewith, £5,180, (about $25,000), so that a sum of £21,230 ($103,000), remains for division amongst twelve professors. Five of them who do not practice privately as physicians receive each an income of about £2,200 ($10,670), and seven who do practice get about £1,460 ($7,080) each. Some people think that these salaries are too high, and would like a redistribution.

New Dispensary in Washington.

A new dispensary, called the Eastern Dispensary, has recently been opened in Washington City, D. C., for the treatment of the poor of the eastern sections of the city. It is to be entirely free, and no member of the attending staff is allowed to receive pay for services rendered.

The attending staff is composed as follows: *Diseases of the Eye and Ear*, Dr. Thomas A. Taylor; *Diseases of the Throat and Chest*, Dr. F. T. Chamberlin; *Surgery*, Dr. Llewellyn Eliot; *Diseases of Women*, Dr. George Byrd Harrison; *Diseases of Children*, Dr. James F. Hartigan; *General and Nervous Diseases*, Dr. John T. Winter; *Skin Diseases*, Dr. Lachlan Tyler; *Dentistry*, James A. Hunter, D.D.S.

Two new features are the exclusion of cases of gonorrhœa, and that every endeavor, by personal investigation and otherwise, will be made to prevent the admission and treatment of unworthy applicants. The dispensary is to be conducted on a non-collegiate and non-sectarian basis.

—The seventh session of the International Congress of Ophthalmologists will be held at Heidelberg, August 9–12, 1888. Three subjects are to come up for discussion: 1. *Glaucoma:* discussion to be opened by Priestley Smith, of Birmingham; and Snellen, of Utrecht. 2. *Cataract:* Gayet, of Lyons; and Schweigger, of Berlin. 3. *Bacteriology:* Leber, of Göttingen; and Sattler, of Prague.

Accident from Phosphorus.

One of the saddest accidents that has happened among St. Louis pharmacists in a long time was reported in the daily papers of March 6. The victim was Mr. James Reilley, whose place of business was at Fourth and Cedar streets. February 1, Mr. Reilley noticed that a jar of phosphorus was getting dry on the shelf and took it down to remoisten it with water, that being the method druggists have of keeping the drug. The jar exploded, burning the skin off the druggist's hand. Blood poisoning set in in the course of a few days, and the unfortunate man was slowly poisoned. He was only thirty-five years old, and leaves a wife and three young children.—*National Druggist*, March 15, 1888.

Homicidal Insanity in China.

According to the law of China, the punishment inflicted on the murderer of a father, mother, brother, husband, uncle, or tutor, and on traitors, is that appalling process known as *ling-chie*, or slow death. The fact that the crime has been committed under the influence of insanity procures no mitigation of the dread sentence, and the miserable culprit is sentenced to be cut into 24, 36, 72, or 120 pieces, a large proportion of which must be accomplished ere the executioner dares to touch a vital part, and end the torture of the victim. Only in certain cases does the Imperial clemency grant death after the eighth division. The commonest form of this penalty is that of twenty-four cuts; and the executioner prides himself on the anatomical skill with which they are administered. The victim being bound to a cross, the butcher by the first two cuts removes the eyebrows, by the third and fourth the shoulders, the fifth and sixth the breasts, the seventh and eighth the flesh of the forearm, the ninth and tenth the flesh of the arm, the eleventh and twelfth the flesh of each thigh, and so on.—*British Medical Journal*, Jan. 21, 1888.

Caffeine.

M. M. Paul and Y. Cowley have succeeded in determining the influence exercised by the process of roasting upon the proportion of caffeine contained in different kinds of coffee. Dry coffee contains from 1.1 to 1.18 per cent. of caffeine. If the roasting is effected at a moderate heat, the loss of caffeine is trifling; but if it be, on the contrary, carried to a high temperature, the quantity of caffeine does not amount to more than 0.36 per cent.

Formula in Dysmenorrhœa.

The following is recommended by Goubert (*Am. Journal Med. Sciences*, April, 1888):

Iodoform	2 grains
Ext. of belladonna	½ grain
Asafetida	.4 grains

M. ft. pil. No. j. Six of these pills are given daily, and from six to ten days before the appearance of menstruation.

American Association of Genito-Urinary Surgeons.

A preliminary programme for the meeting of the American Association of Genito-Urinary Surgeons, to be held in Washington, D. C., September 18, 19 and 20, 1888, has been issued by the Secretary, Dr. R. W. Taylor, of New York. The programme announces the following papers:

Clinical Observations on Diseases of the Testicle. By *Dr. L. B. Bangs*, of New York.

Clinical Observations on Gonorrhœa, and two cases of Cancer of the Seminal Vesicles, with Pathological Specimens. By *Dr. J. P. Bryson*, of St. Louis.

Operative Treatment of Hypertrophy of the Prostate, and Case of Bowel ending in the Urethra of a Child four weeks old; Relief by Operation. By *Dr. A. T. Cabot*, of Boston.

On the Effects of Rapid Changes of Altitude in an Advanced Case of Interstitial Nephritis. By *Dr. George Chismore*, of San Francisco.

Connection between Masturbation and Stricture. By *Dr. S. W. Gross*, of Philadelphia.

Operations on the Kidney. By *Dr. W. H. Hingston*, of Montreal.

Syphiloma of the Vulva. By *Dr. J. N. Hyde*, of Chicago.

The Curability of Urethral Stricture by Electricity; an Investigation; and the Comparative Value of Supra-pubic and Perineal Drainage in Curable and Incurable Bladder Disease. By *Dr. E. L. Keyes*, of New York.

The Filaria Sanguinis Hominis in the United States, especially in its Relationship to Chylocele of the Tunica Vaginalis Testis. By *Dr. W. M. Mastin*, of Mobile.

A Case of Perineal Section for Traumatic Retention; Unusual Condition of the Bladder. By *Dr. J. E. Michael*, of Baltimore.

The Prophylaxis of Syphilis. By *Dr. P. A. Morrow*, of New York.

Unusual Case of Urethral Calculus. By *Dr. H. G. Mudd*, of St. Louis.

On the Radical Cure of Stricture by Dilating Urethrotomy; and Demonstration of a Per-

fected Evacuator, and an Improvement in the Method of Removal of Debris from the Bladder. By *Dr. F. N. Otis*, of New York.

Pyæmia as a Direct Sequel of Gonorrhœa. By *Dr. R. Park*, of Buffalo.

Retrojections in Gonorrhœa. By *Dr. E. R. Palmer*, of Louisville.

Prostatotomy for Enlarged Prostate at the Age of Forty-two. By *Dr. Abner Post*, of Boston.

A Case of Removal of both Testicles for Recurrent Carcinoma, and A Case of Nephrolithiasis Complicated with Hydronephrosis, in which Lumbar Nephrotomy was Performed. By *Dr. F. W. Rockwell*, of Brooklyn.

Some Points on the Differential Diagnosis of Bladder and Kidney Affections, with Demonstrations of the Cystoscope and Other Instruments; and On the Physiology of the Bladder. By *Dr. Alexander W. Stein*, of New York.

Local Treatment of Chronic Urethral Discharges. By *Dr. F. R. Sturgis*, of New York.

Some Points on the Etiology of Stricture of the Urethra. By *Dr. R. W. Taylor*, of New York.

Operative Treatment of Hypertrophy of the Prostate; Spontaneous Fracture of Stone in the Bladder. By *Dr. F. S. Watson*, of Boston.

The Relation of the Prostate to Chronic Urethral Discharges; and The Value of the Tolerance of the Iodides as a Diagnostic of Syphilis; and Urethral Stricture and Enlarged Prostate in their Relation to Vesical Calculus and Calculus Pyelitis, with cases. By *Dr. J. William White*, of Philadelphia.

BY INVITED GUESTS.

The Prognosis of Stricture, based on thirty years' death record of Stricture at the London Hospital and the Practice at St. Peter's Hospital. By *E. Hurry Fenwick*, of London.

The Congenital Anomalies of the Exter nal Urethral Orifice. By *Dr. C. Kaufmann*, of Zurich, Switzerland.

Small-pox in Philadelphia.

A few cases of small-pox have appeared in Philadelphia within the past two weeks. The Health Officers do not think there is any danger that the disease will extend; but a great impetus has been given to vaccination.

Death of Dr. Loring.

Dr. Edward G. Loring, the distinguished specialist in diseases of the eye, dropped dead on the street in New York, April 23, 1888.

Trichinosis in Indiana.

It is reported from Richmond, Ind., under date of April 13, that a whole family in Ridgeville, Randolph county, was suffering with trichinosis. Dr. Helms was called to attend the patients, and discovered the presence of trichinæ in a ham which they had been using for food.

Pennsylvania State Sanitary Convention.

A Sanitary Convention under the auspices of the State Board of Health of Pennsylvania is to be held in Lewisburg, on May 17 and 18, 1888. Governor Beaver is to make the opening address, and Hon. S. T. Davis, M.D., of Lancaster, the annual address. Papers are promised on The Prevention of Contagious Ophthalmia, by Dr. P. N. K. Schwenk, of Philadelphia; on Diseased Meats and the Prevention of Trichinosis, by Dr. G. W. Furey, Sunbury, Pa.; on The Water Supply of Lewisburg, by Prof. W. G. Owens, Bucknell University; annual address, Hon. S. T. Davis, M.D., Lancaster, Pa.; on Cremation as a Means of Disposal of the Dead, by Dr. B. F. Hyatt, Lewisburg, Pa.; on Small-pox in Country Places, by Dr. Fetterolf, Mazeppa, Pa.; on Hygiene of the Teeth, Dr. F. Gerhart, Lewisburg, Pa.; on Insanity Among Women, Alice Bennett, M.D., Resident Physician State Hospital for the Insane, Norristown, Pa.; on Sanitary Protective Associations, by Benjamin Lee, M.D., Secretary of the State Board of Health; on Sanitary Shortcomings of Lewisburg, by Dr. W. B. Atkinson, Secretary of Pennsylvania State Medical Society, and Medical Inspector of the State Board of Health; on School Hygiene, by Dr. G. G. Groff, of Lewisburg, member of the State Board of Health; on Household Hygiene, by Dr. Francis Emery White, of the Woman's Medical College, Philadelphia, Pa.; on How Germs Cause Disease, by Dr. V. C. Vaughan, of Michigan University; on The Drainage of Lewisburg, by M. S. D. Bates, Lewisburg, Pa.

The aim of the meeting will be to make the paper of practical use to the citizens of Lewisburg and its neighbors, and to enlist them in the study of its sanitary problems. For this reason they will be of great interest to all residents in small towns and rural districts, the conditions of which are necessarily very similar.

NEWS.

—Dr. R. P. Brochin, editor of the *Gazette des Hôpitaux*, died in Paris, March 25.

—Dr. C. P. Wilkinson has been elected President of the Louisiana State Board of Health.

—A bill incorporating an institute for teaching "Christian Science" has passed the Legislature of New York.

—Professor Wilhelm Leube, of Würzburg, has been appointed to the Professorship of Clinical Medicine at Leipsic.

—The telegraphic reports of the condition of the Emperor of Germany indicate an alarming change for the worse.

—Dr. Hermann Krause, *privat-docent* in laryngology at Berlin, has been granted by the Emperor the right to the title of Professor.

—The Medical Department of the Western Reserve University has decided to lengthen its course to three years, beginning next fall.

—Dr. Thomas Keith, the distinguished gynecologist, has resigned his position in the Edinburgh Royal Infirmary, and removed to London.

—Dr. George M. Sternberg, U. S. A., who was last year commissioned by the President of the United States to study in Brazil the protective value of inoculation in yellow fever, presented to the College of Physicians of Philadelphia the results of his researches in an interesting address on Saturday evening, April 21.

—Dr. Anna Kingsford, who recently died in London, believed that she was the re-embodied spirit of Lady Jane Gray. She visited the Tower of London one day, in the body of Dr. Kingsford, and became acquainted with herself, as it were. Dr. Kingsford was a very brilliant woman and learned languages and history with wonderful ease.

—The *Sacramento Medical Times*, April, 1888, says that small-pox is evidently subsiding in every part of California from which it had been reported, excepting Angels, Murphys and San Andreas, in Calaveras county, where it appears to have been mistaken for chicken-pox, and where it has consequently obtained a foothold sufficient to necessitate the intervention of the State Board of Health. All of the cases, however, being now quarantined, and thorough and systematic vaccination having been inaugurated, it is not doubted but it will be confined to the few persons already attacked. The cases are also reported to be of a mild type, as are also the few which are still occasionally reported from San Francisco and other localities.

HUMOR.

His Own Diagnosis.—Mother—And do you really feel so very bad, Bobby? Bobby—Yes, ma. I ain't quite sick enough to need any medicine, but I'm a little bit too sick to go to school.

Bobby—Ma, did the doctor bring me in the day-time or night-time? Mother—In the night-time, Bobby. Bobby—Well, I guess that's the reason I don't remember anything about it; I must have been asleep. —*Harper's Bazaar.*

"Well, how is this, my dear sir?" inquired the local practitioner; "you sent me a letter stating that you had been attacked by small-pox, and I find you suffering from rheumatism." "Well, you see, doctor, it's like this," said the patient; "there wasn't a soul in the house who could spell rheumatism."

A Wise Mother.—Aunt: "Can you get your cod-liver oil down, my child?" Little patient: "It tastes horrible; but mamma gives me five cents every time for my savings-bank." Aunt: "And, what do you do with the money, my dear?" Little patient: "Oh, mamma buys cod-liver oil with it."—*Fliegende Blätter.*

Those Cruel Medical Students.—(Dr. Carver has disappointed his quiz class to dine with a wealthy patient.)—Butler (reappearing after answering the front-door bell)—"Doctor, dey's a gemplemum outside what say he come like you tole him call at harf-pas' seving, an' say Mrs. Lenox Hill wan' to see you right 'way!"—*Puck.*

"I haven't had no lesson since yesterday," pouted Johnny. "That means you have had a lesson," said the teacher. "Who remembers what I said this morning about two negatives in a sentence?" "I do, I do," yelled the smart boy on the front seat. "You said two negatives made one infirmity."—*Texas Siftings.*

Convalescent (to physician)—I see your bill, doctor, calls for $10. How much do you charge a visit? Physician—Two dollars. Convalescent—But you only called three times. Physician—Five times, my friend, three times for treatment and twice for my money. Convalescent—I guess I had better hurry and pay up.—*The Epoch.*

A Georgia negro, having hurt his leg, treated the wound with mud from the Ocala swamp, and found when he removed the bandage that the wound was healed and that the leg had turned almost white. The result is that the negroes of the vicinity are flock-

ing to the swamp and covering themselves with the mud, hoping it will turn them white.

A SMALL BOY of Springfield, Mass., went to the grocery to get some things for his mother, but when he tried to recall one of the articles he couldn't think of the name. He said it was yellow, and in various ways tried to give the clerk an idea of what he wanted, and finally in desperation blurted out: "Why, you know what I mean—that stuff that they burn in hell!" Then the clerk got him the sulphur that he wanted, and the orthodox child went home happy.

OBITUARY.

CORNELIUS R. AGNEW, M.D.

The many friends of Dr. Cornelius R. Agnew, of New York, have been pained by his death after an attack of perityphlitis, for which the operation of laparotomy was performed on April 13, by Dr. Sands. For a short time the operation gave him relief, but it failed to save his life, and on April 18 he died. Dr. Agnew was born in New York in 1830. The family settled first in Philadelphia and afterwards removed to New York. He studied at Columbia College, New York, graduating in 1849, and then studied medicine in the New York College of Physicians and Surgeons. He graduated in medicine in 1852, and in the following year became House Surgeon in the New York Hospital. Soon after he went to Europe and studied in Dublin, London and Paris for two years. Returning to America in 1855, he established himself in New York as a general practitioner, and until 1864 was surgeon in the Ear and Eye Infirmary. In 1858 he was appointed Surgeon-General of the State of New York by Governor E. D. Morgan, and at the commencement of the Civil War the same Governor appointed him Medical Director of the State Volunteer Hospitals of New York, a position of great trust. When the famous Sanitary Commission was organized Dr. Elisha Harris and Dr. Cornelius R. Agnew were unanimously elected as colleagues, and it is explicitly stated in Dr. Charles J. Stillé's history of the Commission that the success of that enterprise was very largely owing to Dr. Agnew's labors. Dr. Agnew was one of the surgeons who prepared the plans for the "pavilion hospital system" generally followed during the war.

AZARIAH LYCURGUS KIMBRO, M.D.

Dr. Azariah L. Kimbro died in Memphis, Tenn., March 17, 1888. He was sixty-two years old at the time of his death. He was graduated from the Botanic Medical College, of Cincinnati, Ohio, in 1846, and subsequently practiced medicine in Franklin, Tenn., until 1848, when he removed to Memphis. He leaves a wife but no children.

D. JEROME SANDS, M.D.

Dr. D. Jerome Sands, of Port Chester, New York, died February 29, of pneumonia. He was seventy three years old, was graduated from the College of Physicians and Surgeons, New York, in 1840, and leaves a son who is a physician.

ALBERT G. BROWNING, M.D.

Dr. Albert G. Browning, of Providence, R. I., died of apoplexy, April 5. He was graduated from the Medical Department of Yale College in 1863, and for nearly 25 years practiced medicine in Providence, being highly esteemed for his skill and integrity.

Changes in the Medical Corps of the U. S. Navy for the week ending April 21, 1888:

Medical Inspector A. C. Rhoads, detached from special duty New York, and waiting orders.

Passed Assistant Surgeon L. G. Henneberger, detached from Naval Hospital, New York, and to special duty attending officers and families, New York.

Official list of changes in the Stations and Duties of Officers serving in the Medical Department, U. S. Army, from April 15, 1888, to April 21, 1888:

Major George M Sternberg, Surgeon, having been instructed by the President to proceed to the island of Cuba, for the purpose of continuing his investigations of the methods of preventing the spread of epidemic diseases, will, in connection with his present duties, report to the Secretary of the Treasury for further instructions, S. O. 89, A. G. O., April 18, 1888.

Capt. Clarence Ewen, Assistant Surgeon, granted leave of absence for six months, with permission to go beyond sea. S. O. 85, A. G. O., April 13, 1888.

Capt. William H. Arthur, Assistant Surgeon, ordered from Fort Niagara, N. Y., to Fort Bowie, Ariz., to take effect on the expiration of his present leave of absence.

First Lieutenant Charles S. Black, Assistant Surgeon, ordered from Fort Davis, Tex., to Fort Sidney, Neb. S. O. 86, A. G. O., April 14, 1888.

The operation of par. 17, S. O. 79 c. s., A. G. O., (as much thereof as relates to Capt. Geo. E. Bushnell, Assistant Surgeon, U. S. Army), is suspended until May 1, 1888. S. O. 90, A. G. O., April 19, 1888.

First Lieutenant Wm. D. Crosby, Assistant Surgeon, ordered for duty at Jefferson Barracks, Mo., after being relieved by Assistant Surgeon William H. Arthur, and upon the expiration of the leave of absence granted him in S. O. 60, A. G. O, March 14, 1888. S. O. 86, A. G. O., April 14, 1888.

Appointment.

Ogden Rafferty, to be Assistant Surgeon with rank of First Lieutenant, March 26, 1888.

Promotion.

Captain Joseph B. Girard, Assistant Surgeon, to be Surgeon, with the rank of Major, March 22, 1888.

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Clinical Lecture.

ON FRACTURE OF THE LOWER END OF THE HUMERUS.

BY J. S. WIGHT, M.D.,
PROFESSOR OF OPERATIVE AND CLINICAL SURGERY AT THE LONG ISLAND COLLEGE HOSPITAL.

Gentlemen:—This boy is eight years of age. Two weeks ago he fell on his left elbow and broke the lower end of the humerus. His injured limb has been supported by a posterior splint, so that the forearm has been about midway between a right angle and complete extension. You may know that such a case is important, when I tell you that its diagnosis is uncertain, that it is difficult to treat, and that the results cannot always be known beforehand.

When such an injury occurs, and is presented for your examination and treatment, you have two standards for your guidance. First: In your general study of anatomy, you have formed and carry with you some ideal of the structure and uses of the elbow-joint. With this more or less correct ideal you compare the injured limb, and make a note of the signs. Second: You carefully examine all the land-marks of the other elbow. This is your best standard of comparison. Keep one hand on the normal elbow, and the other on the one that has been injured. At each and every point contrast and compare the injured with the normal structure. An analysis of your impressions will give you additional facts, which will aid you in your diagnosis. Then see how much the motions of the forearm on the injured side have deviated, and try to determine the causes that have impaired these motions. Is there a fracture of the bones at the elbow? Has the elbow-joint been sprained? And what is of the greatest importance, we should always ask if the injured part has suffered injury or disease at some previous time. We may not mistake the results of an old injury for the effects of one that is recent. An injury to a diseased joint brings two conditions to our attention: how much of the disorder was caused by the disease; how much of the damage was produced by the injury.

Let us begin our examination by noting the land-marks of the uninjured elbow. The head of the radius and the external condyle are formed to project equally on the outside; one is as prominent as the other. I have very rarely seen an exception to this rule of conformation. The ulna appears to be on a line with the humerus, just as if it were the prolongation of that bone. And the curve of the radius and the expansion of the radial base cause the forearm to meet the arm at an obtuse angle. The internal condyle is prominent, as well as the olecranon process of the ulna. Mark the groove between these two processes, and keep in mind the distance of one from the other. See the way in which the olecranon moves to and fro during extension and flexion of the forearm. Remember that at the age of our patient the lateral motion of the forearm, so common in early life, has mostly disappeared. In our patient this evanescent function is absent. In fine, the motions of flexion, extension and rotation of the forearm of the uninjured limb are practically normal.

I have already told you that this boy had broken the lower end of his left humerus: I expect to prove this conclusion beyond the possibility of a doubt. But in the mean time let me say to you, that the changes taking place in the lower end of the humerus, as it develops, have important bearings on the causation, nature, treatment, and the results of fractures, such as we have illus-

trated by the case of our patient. I allude to the epiphysis and the cartilage between it and the diaphysis. In our patient ossification is going on in the end of the humerus adjacent to the radius, the external part of the ulna, and the internal condyle. And it seems to me that this change from cartilage to bone, which occurs in the ends of long bones, is sometimes a reason why a fracture happens so often in this location. In making this statement I do not underestimate the influence of other causes. But I am inclined to the opinion that this ossifying cartilage, though the change goes on very slowly, resembles provisional callus; for both are apt to yield and even break under the impact of external violence. The bearing of this ossifying structure on the nature, treatment and results of such fractures will receive our attention, when we have made our diagnosis.

Let us inspect this injured limb and see what we can find. The condyloid end of the left is greater in width than the corresponding end of the right humerus. Measurements by the calipers show that the lower end of the right humerus is about an inch and three-fourths in width, and that the lower end of the left humerus is about two inches in width, demonstrating the fact that the injured elbow, from some cause, has been made wider than the other. The forearm of the injured limb bends and falls to the inner side. The external angle usually made by the forearm and the arm at the elbow-joint is obliterated, and an internal angle is formed. The entire forearm is displaced inward nearly one-fourth of an inch. Observe this somewhat sharp prominence just above the place where we ought to find the head of the radius. You can see that the head of the radius is displaced inward, and part of the radial head of the humerus has gone along with it, leaving a rough end of broken bone under the skin and fascia. This rough end can be seen, and can be distinctly felt. How can the upper end of the radius move inward and not take the upper end of the ulna along? And we find that the ulna has moved inward about one-fourth of an inch. But, as you see, the internal condyle has also moved inward. And if we measure, we shall find that the internal condyle and the upper end of the ulna have nearly the same relations on the injured as they have on the normal side; the apex of the internal condyle is about as far from the olecranon on one side as on the other. And we discover a deeper curve on the inner aspect of the left arm just above the elbow than in the same location on the right arm. It seems as if the more internal parts of the left humerus, near the internal condyle, had been bent inward, without giving way entirely, producing a form of incomplete fracture. The age of our patient would be in favor of such a conclusion.

Now we may consider the displacements of the fragments, for we may assume that the lower end of the humerus has been broken. The head of the radius and the radial head of the humerus are, as you can see, displaced backward somewhat further than the upper end of the ulna, the trochlea and the internal condyle. The lower articular end of the humerus is displaced inward about one-fourth of an inch. This lateral displacement is as great as the shortening of the injured humerus. It seems that the lower end of the upper fragment is displaced outward and somewhat forward about one-fourth of an inch.

The motions of the elbow-joint are impaired. The forearm can be moved to a point about twenty degrees from complete extension, and from thence nearly to a right angle with the arm. It has lost more than one-half of the function of flexion and extension. The left forearm has about thirty degrees less rotation than the right. Its lateral motion has been somewhat augmented. These motions are passive. They are made by the surgeon. The voluntary motions of this elbow-joint are very much impaired, not only on account of the mechanical obstructions, but also on account of the pain and the tenderness. In fact, the motions are not all confined to the joint. There is mobility in the continuity of the lower end of the humerus. The radial head of the humerus is broken off obliquely inward and upward, and there is a line of separation between it and the trochlea, so that the motion of the fragment is added to the motion of the elbow-joint. The simple fact is that the head of the radius has left its normal relation with the external condyle. The fracture extends obliquely upward and inward from the fragment just described, displacing inward the internal condyle, which is not completely detached from the shaft of the humerus, and yet the separation is sufficient to add some mobility to the elbow-joint.

In this place let me call your attention to the nature of some fractures that occur in the condyloid end of the humerus, and to the position of the forearm in the case of this patient. I have seen a number of cases of incomplete fracture in the ossifying cartilage of the condyloid end of the humerus. These cases have occurred in boys from six to fifteen years of age. In the case of this

boy the fracture is mostly complete. The lower end of the diaphysis of the humerus is split upward and inward, and the fibres of the bone on the internal aspect above the internal condyle are partly broken and partly bent. It seems as if the olecranon had acted as a wedge to penetrate to some extent the intercondyloid tissue, and aid in no small degree the displacing effects of the external violence that was applied at the time of the fall. I think that there can be no doubt of the existence of a fracture of the lower end of the humerus in this case. It is complete on the outside, and it is incomplete on the inside of the humerus.

Let me say to you that from time to time I have seen incomplete fractures, that have occurred in the ossifying cartilage of the lower end of the humerus. These fractures traverse the tissue vertically, obliquely and transversely. They are most apt to occur in boys, between the ages of six and fourteen years. The structure seems to split for a certain distance, and form a wedge-shaped opening, which is usually filled up by the material of repair. The displaced fragments, are, for the most part, irreducible. Had we the time at our disposal, I could give you the clinical history of a number of these cases coming under my observation and treatment.

Let me give you a few words in regard to the position of the forearm in the case before us. Since the ulna is attached to the inner fragment, and since that fragment is bent inward, and since the radius is attached to the outer fragment, and since that fragment is displaced backward, it follows that the entire forearm is rotated outward to some extent. This is one of the displacements of the forearm, which has followed the lower fragment of the humerus in its internal angular displacement. Let me call your attention to some points of scientific and practical importance in regard to the attitude of the forearm. The space between the ulna and radius is greatest when the forearm is in a position of mid-rotation, and the radius approaches the ulna from this position to complete pronation, as well as to complete supination. And when the forearm is flexed to a right angle with the arm, carried across the chest, and kept vertical, so that the radius is directly over the ulna, the bones of the forearm will be in the same plane, and will be at their greatest distance from each other. This plane of the forearm, as you see, meets the long axis of the arm at an acute angle that differs as to size in different patients. Now I have often given you reasons why the forearm as a rule ought to be put in this position during the treatment of fractures in the vicinity of the elbow-joint. This position tends not only to equalize the antagonism of the muscles that span the elbow-joint, but it also conduces to the reduction of the displaced fragments of bone. And if we construct a splint on the mechanical principles suggested by the conformation, the structure and the muscular apparatus of the elbow and its relations, it will accomplish two important indications: we can make a more complete reduction of the displaced fragments, and the patient will have the greatest relief from pain. I have proved these two propositions in a practical way on many occasions. More than once I have been surprised at the completeness of the reductions of the bony fragments, as well as their retention in position during the process of repair. Often patients have expressed relief from pain, when this form of splint has been applied.

This apparatus would appear to be an unnecessary refinement—and so I have been told. In reply to this, let me say, that the surgeon is morally bound to give his patient as much freedom from pain as he can. He is bound by the same kind of obligation to apply his best skill in the treatment of the case. He must reduce the fragments in so far as it can be done safely. He must put in practice those principles which will, according to his best judgment, restore and conserve the functions of the damaged structure to an extent which will be consistent with ordinary skill; and he may go as far beyond that as he can. The ambition of the surgeon ought to lead him in the direction of the highest success. Now in my hands this splint, having two angles as above described, has accomplished good results. In fact it has answered a better purpose than any other that I have employed; and so I recommend it.

You will see that the motions of this elbow-joint are very much impaired. And then you ask—what is the cause? Let me explain: The joint surfaces which fitted and moved in opposition before the injury, have been deformed, so that the parts have lost their adjustment, and so that the projecting points of bone on both sides of the joint meet and obstruct each other. And since the fragments have been only imperfectly reduced, the obstructions to the motions of the joint must continue to operate. But the case does not remain in this condition. The process of repair has furnished new material between and around the fragments, so that the obstructions to motion have been augmented. In fact, the process of repair works in the

direction of making the fragments grow together, and does not seem to have any special purpose in restoring the motions of the joint. In addition to this, bands of adhesion, as they are called, attach one part to another so as to further impede the motions which have been impaired.

And then there is another point connected with this injury: I mean that there has been some damage done to the neuro-muscular apparatus. In a healthy joint which has not been injured there is a coordinate relation between the nerves and muscles concerned in the motions of that joint; and the bony levers are involved in this relation. That is, we have a triple relation of bones, muscles and nerves. Damage to either factor will derange the entire coordinate relation so as to interfere with the performance of function. The bony supports, as points of resistence and surfaces of motion, have been seriously damaged in this case. The nerves have been injured and irritated. The nerves send messages to the muscles, not to make them keep quiet, but to cause them to contract, and they do so without discretion. The fulcrum of the bones of the forearm is in pieces and can not normally sustain the force of the contracting muscles that span the elbow-joint. Now the muscles not only displace the fragments by traction on the bones, but they will also in time become shortened; they will become *contractured.* And then, as you now see, we have another reason why such an injury, as the one before us, impairs the functions of the part in which this triple relation of bone, nerve and muscle has been deranged.

Let me tell you another thing which sometimes leads to a difference of opinion among surgeons, and is apt to be a cause of controversy. I mean this: That these cases of injury to the elbow-joint, accompanied by fracture of the condyles of the humerus, eventuate in very different results in different cases. It is the old story, which we are all so slow to learn, which begins in the constitutional condition of our patients who are not all put together with the same physical consistency. One patient will have a trivial injury to the elbow, and be left with the functions of the parts greatly impaired. Another will have a severe injury, even involving a compound fracture of the condyles of the humerus, and have a recovery that is almost perfect. Both of these cases may be treated on the same plan and with the same degree of skill; even the one that has resulted with the greatest disability may have been treated with greater care and skill than the other. The difficulty does not exist in the treatment, but comes out of the physical condition of the patient. Hence it has occurred that one surgeon has had a series of cases of fractures of the condyles of the humerus, in which good results have supervened, and then he extols the plan of treatment that he has pursued; and perhaps he may come to the conclusion that he can always prevent disability in cases of fracture of the elbow. I need not emphasize the fact that this surgeon is mistaken. On the other hand, another surgeon may have had a series of these cases of fracture, and may have had them all in the main result in more or less disability. Let him not be discouraged for he may have treated his cases with more than ordinary skill. The results may have been due to the intrinsic difficulties of the cases, which no one can overcome. Let surgeons reason together; let no one be discouraged; let no one be unduly exalted. It is easier to criticize work than it is to perform it; and the apparent results are not always the index and the measure of the skill that has brought them about.

There is one point connected with fractures in the vicinity of joints in regard to which you may be in some doubt. This point relates to passive motion. On passive motion there are many different opinions among surgeons. One says, begin passive motion soon after a fracture occurs; another says, institute passive motion at the end of three or four weeks; and still another says, make passive motion when six or eight days have elapsed. Again, one surgeon says, make passive motion every other day; a second says, make passive motion every third or fourth day; and a third says, make passive motion about once a week. Each one of these precepts has given good as well as bad results; and this means that the methods are not so much at fault as the condition of the patient and the circumstances of the case. Your difficulty, when there is so much uncertainty, will be to know what to do in a case of fracture of the elbow, for instance.

In the light of experience, let us analyze this subject of passive motion. What is the object of passive motion? Practically, it is to prevent, as far as possible, the impairment of voluntary motion. When the fragments have grown together, it is desirable not to have a disabled joint in the vicinity of the fracture. What events are apt to occur in the vicinity of the elbow-joint, when there is a fracture of the condyles of the humerus? The inflammation, incident to the process of repair, may implicate the

tendons and their sheaths, as they span the joint, and leave adhesions that may interfere with voluntary motion. Also the inflammation may agglutinate the various forms of connective tissue about the joint, so as to aid in the production of disability. The new material that is formed for the repair of the broken bone, as we have indicated, will be a potential cause of anchylosis. Now what will be the effect of passive motion on the formation of adhesions between the layers of connective tissue as well as between the tendons and their sheaths? Passive motion of proper kind and degree, in the great majority of cases, will be instrumental in preventing, or limiting the formation of such adhesions. Sound theory, as well as abundant experience, has corroborated this conclusion. Severe injury and excessive inflammation might interfere for a time with our attempts to make passive motion. In the next place, would passive motion interfere with the formation of callus? and would it cause the displacement of the fragments? In a case of incomplete fracture, or when the fragments could not be reduced, passive motion would not cause displacements. In any other case, except when there is great swelling of the soft parts, it is possible, as a rule, for the surgeon to hold the fragments in place as he makes careful passive motion. I have often verified this practice. In regard to the new material that is going to be transformed into bone: in general, the pressure produced by the passive motion will make the new ossifying material yield and cause it to be absorbed, so that the bones of the forearm can be flexed and extended more and more, thus conducing to a better result.

Now, what kind of passive motion shall we make in these cases? Let it be gentle, so as to prevent adhesions between the tendons and their sheaths, and so as to keep the new ossifying material from obstructing too greatly the motions of the joint. As a rule, let passive motion begin from three to five days after the fracture has occurred, and let it be repeated every three or four days from that time till treatment is no longer required. There is no fixed time for treatment to continue; one case may need passive motion only a few weeks, and another may need it as many months. Let me illustrate: One boy, about nine years of age, broke the condyles of his left humerus, and in six or seven weeks had good union, with nearly perfect restoration of the motions of the forearm. This case was treated on the plan above described. Another boy, about fourteen years of age, broke the condyles of his right humerus, and, after ten months of the most persistent and careful treatment, had firm union of the fragments, but could flex and extend the forearm only about one-half the normal distance. The constant tendency in this case was to anchylosis. On several occasions I administered ether and broke up the adhesions, causing some absorption of the new bone, so as to augment the extent of the motion.

One of the possible sequences of passive motion must be mentioned. There may be fibrous union between the fragments of bone, leaving a new point of motion, with the joint more or less impaired. This condition may not augment the deformity to any great extent, and it will not very greatly diminish the strength of the joint, while it may increase the motions of the forearm. Now, it might be that motion of the forearm would be more desirable than resistance of the elbow-joint, so that fibrous union of the bony fragments might be more useful than anchylosis. And let me add that I have seen fibrous union take place when the case has been treated without passive motion. Also, I have seen the condyloid fragments mostly absorbed, so that the motions of the forearm have been very much greater than normal. Furthermore, I have seen two sets of cases: one in which the forearm could not be flexed above a right angle, not only on account of the projection of the lower end of the upper fragment, but also on account of the formation of new substance in front of the elbow-joint, but the extension of the forearm has not been greatly limited in such a case. The other set of cases has exhibited a persistent tendency to flexion of the forearm even above a right angle, and has presented such obstruction to extension as has been very difficult to overcome. The difficulty in such a case appears to depend on resistance to the olecranon by new substances formed in the olecranon fossa, as well as on contracture of the flexors that span the elbow-joint.

—Dr. Cullimore asserts (*British Medical Journal*) that 10 drops of a fluid extract of phytolacca decandra, repeated a few times, aborts inflammation in mastitis. The drug acts as a general narcotic, but only in a favorable way. In larger doses it excites vomiting and diarrhœa, which may be followed by coma and death. It may also be used externally directly to the breast, or in the form of compresses. Dr. Cullimore thinks it is likewise active in orchitis and epididymitis.

COMMUNICATIONS.

QUININE—ITS USE AND ABUSE.

BY HIRAM CORSON, M.D.,

CONSHOHOCKEN, PA.

Many persons write of quinine and its value in various diseases: to reduce the frequency of the heart's action; to abate the temperature; as an antipyretic in pneumonia; as a promoter of sleep in nervous affections; for the relief of pain in neuralgia; as a tonic in all weak conditions of body; as a remedy for those every-day "bad feelings" which beset many of us; and, above all, as an antiperiodic in all diseases which can be traced to the influence of malaria, and in all others not readily diagnosticated. I need not have spoken of so many diseases, for now we have almost none but malaria and those caused by germs. Even malaria is likely to be displaced as a cause of disease, for all bad-airs are now looked upon as germs which are seeking whom they may devour. We are apt to carry the use of even a good medicine too far; to use it when not needed, oft-times, too, to the injury of the patient; and, even when needed, in extravagant, if not harmful doses. During the last twenty or thirty years such has been the case in relation to the use of quinine. Just before Dr. Brinton ceased to edit the MEDICAL AND SURGICAL REPORTER he published an article from a correspondent on the use of quinine, in which the doses used were small, compared with those now in common use; so small that the editor felt that it was needful to call attention to it, by a note appended, in which he stated that *small doses given so far from the expected paroxysm are utterly useless to arrest an intermittent disease.* I do not quote his words. This attracted my attention, and I have since observed that this opinion is in accord with the opinions of those who are in the habit of freely using quinine, and who see a malarious origin in nearly every disease, not due to germs. Large doses given near to the time of the expected paroxysm in intermittent fever—twenty, forty, seventy grains a day; yea, as much at a single dose is vauntingly, triumphantly spoken of as an improvement on old time practice. In view of the opinions and practice of the present time, it has occurred to me that it may be useful to speak of this medicine and its value as a remedy in the diseases in which I have used it for more than sixty years.

Our necessities sometimes teach us valuable lessons. When, in 1826, I began the study of medicine at New Hope, Pa., intermittent fever prevailed extensively along the Delaware river from Bristol to Easton. We hear much now about "malaria." It is spoken of as a *disease*, not as a *cause* of disease. The one disease which every physician in our country acknowledges as the one undoubted malarious affection, is intermittent fever. It was this disease which in the fall of 1826 I had daily opportunities to see in its varied forms, from the simple ague, with its daily shakes, to the tertian with its every other day, and the quartan with its third day paroxysms.

At that time my preceptor told me that he was paying $16 per ounce for sulphate of quinine, and that a few years before that time the cost was $26 per ounce. This price will seem almost incredible to physicians of the present day. Fearing that this statement might be doubted, or attributed to the forgetfulness of old age, I wrote to Powers & Weightman, successors to "Farr and Kirnzic," at that time the manufacturers of the article—and have received the following answer: "In regard to the price in 1826 being about $16, and some time previously $26, we think you are substantially correct." * * * * "We have a friend in Cleveland, Ohio, who said some time ago, that he remembered buying from Farr & Kirnzic, about 1825, at $24 per ounce, and we think he is correct." At twenty-four dollars per ounce, the cost per grain would be five cents. It is easy to believe that a physician who furnished the medicine to his patients had need to be economical in the use of an article so expensive, and would try to discover the least amount on which he could rely to cure an intermittent fever, the principal disease then occupying his attention. Grand opportunities physicians had too, for observing its effects and the amount needed to insure an arrest of the disease. There were hundreds of cases. Every day, or every other, or every third day a chill, of perhaps a whole hour, followed by pain in the head, high fever, sometimes delirium for several hours, succeeded by profuse perspiration, subsidence of the former symptoms, and then for a few hours comparative comfort until the return of the paroxysm and its attendant ills. While some of them would be seriously ill confined to the bed, some others in the same family, would be up during the interval.

As we passed into the fall of 1826 I saw with my preceptor many patients suffering with the various forms of intermittent fever,

which prevailed to a distressing degree on both sides of the river. His inability to attend to all the cases caused him to assign a certain district to the care of another student and myself. This strip of three miles in extent, from "Ingham's Spring" to the river Delaware, was studded with mills and factories, at each of which were a large dam and a long race filled to the brim at night, but drawn down somewhat during the day. Here with these sick men and women, boys and girls, all suffering from some form of fever—which would now be called malaria—we exercised the little skill we had for their relief. My fellow-student had been doing "some practice" for several months before I entered the office, and he, therefore, did the prescribing. Day after day we made our trips up the "race" attending to the sick, and oh! how sick some of them were. There were all the common forms of intermittent and we could generally cure them without difficulty or delay. But there were also some cases which did not get well so readily—were not decided intermittents; these were called remittents, or bilious fevers, and though quinine was used in the treatment occasionally, the great disorder of the stomach, high fever, occasional delirium, pain in the head and almost jaundiced condition of the skin, indicated as we then believed the use of calomel and febrifuges.

In the pure intermittents our usual treatment was ten grains of sulphate of quinine in one or two grain doses every hour, or two hours, dependent on the length of time of the interval between the appearance of perspiration and the time of the expected chill. We deemed it quite important to exhibit the medicine as soon as possible after the abatement of the hot stage and appearance of perspiration; in other words, *as far from the time of the expected chill as possible.* Our practice as you see, was the very reverse of that spoken of and advocated by Dr. Brinton, yet, I do not speak of it as being the proper one, but merely state the fact. If in the interval we could give ten grains every hour, in the fore part of the intermission, we felt almost certain it would prevent another attack the following day, or at farthest, the next day, if the case were a quotidian. Scores and scores of cases were thus arrested, though the patients had such poor doctors. During the sixty years, which have since passed, hundreds and hundreds — may I not say thousands — of cases have I arrested with this small amount of this valuable medicine. After I graduated in 1828, the disease prevailed along the Schuylkill river and throughout my whole region, and my practice was the same as while at New Hope. Called to a patient, I would generally be able from the history given to me, to ascertain whether it was a quotidian, tertian, or quartan. If the first, I gave ten grains as already stated; if a tertian, the ten grains were used in the same way and infusion of gentian ordered for the next day; if a quartan, the same practice was followed, but sometimes ten grains were given twice in the interval. When at New Hope it prevailed so greatly, there were also cases of pernicious intermittent fever, which, if not arrested, generally proved fatal during the third chill, reaction failing to appear. In these cases, as there was a possibility of failure in the ten grain dose, and as the peril was extreme, thirty grains were given to the patient during the interval, by giving three or four grains every hour. In no case which I saw with my preceptor there, did thirty grains fail to save the patient. At the time at which I speak, there came to the place a young graduate of the University of Pennsylvania, born and educated in Philadelphia, where intermittent fever did not prevail. He had probably never seen a case of the pernicious kind, and had had no opportunity to become acquainted with it. He had very influential relatives there and soon had patients. He encountered some cases of pernicious intermittent fever which carried off three prominent men, doubtless from the fact that he treated them as he did his ordinary cases. In 1835 I was called to an apprentice of a joiner, 19 years old, who had had his second chill. I saw him at 2 P.M., three hours after the chill began. He was as prostrate as a man in typhus fever; his parents had been sent for, as he was thought to be "sinking." It was apparent to me that this was a regular quotidian, but a most pernicious one; but, as he had lived through the chill, I felt confident that if I could prevent another he would be saved. The thirty grains were given before day-light next morning. He escaped the chill that day, and the next day he sat in the carriage and rode to his home two miles away, apparently and really well.

I am not now advocating the propriety of giving only ten grains to arrest an intermittent fever, or the safety of trusting a pernicious one to thirty grains, but merely stating facts, and showing the control which these comparatively small doses had over that active malarial disease. The pernicious fever was recognized and noticed by medical writers as early as 1822—possibly earlier. From 1822 till 1832 intermittent and remit-

tent fevers prevailed distressingly in what were then called ague districts; but after the advent of the cholera in 1832, they were greatly diminished in numbers, until 1842, when few cases, comparatively, presented themselves. So numerous were these fevers during the first four years of my practice, that if I were to name the numbers occurring in a single season the statement would scarcely be credited. Many times I have seen a majority of the family suffering from intermittents and remittents at the same time, and in some instances have seen every member of the family ill at the same time, one not being able to help another. And how various were the symptoms of this disease! Sometimes only a violent pain over one eye; in one case severe pain in the "head" of the penis, recurring every day at the same hour. In two cases, uticaria over the whole body, disappearing with the perspiration, to recur again at the usual hour, and all relieved by the quinine, as in an ordinary ague. Wherever the periodicity was well marked quinine in the doses named was an efficient remedy.

In a paper published in the MEDICAL AND SURGICAL REPORTER, July 2, 1887, by Dr. Mary Putnam Jacobi, on "Quinine in Pneumonia," she says: "I do not understand Dr. Corson's general denunciation of quinine as a dangerous agent." It will be seen by this paper that I do not regard it as a dangerous agent, and that in my reference to the proofs, given by herself and six other New York physicians, of the utter uselessness of it in pneumonia in their cases, I (in my review of their experiments) objected to its use because its exhibition was useless, sometimes fatal, by taking up precious time to the exclusion of better means of cure. Now let me kindly say, in her own words: "I do not understand how Dr. Jacobi dare recommend its use in pneumonia after proving its worthlessness in that disease." I regard quinine as next in value to opium, but I am disgusted with the disposition to regard malaria as the cause of every disease (not already assigned to germs), and quinine in large, injurious doses as the remedy. There are very few cases of malarial disease now—not more than one in fifty, so-called. It is so handy, when we can't diagnose a disease, to say it is malaria, that we hear it on all occasions, if not as the disease, at least as that which gives character to and aggravates the real disease, and that the treatment must be of a kind adapted to the entire removal of the malaria from the system. Should a new doctor be called to a case which convalesces slowly, he often finds that "the other doctor has not gotten all the malaria out of your system; no wonder that you could not get well."

About forty years ago "spinal disease" was as prevalent as "malaria" is now; thousands of backs were covered with pustules from the nape of the neck to the sacrum; now it is almost unknown.

In a most valuable paper by Dr. James W. Price, in the MEDICAL AND SURGICAL REPORTER of March 10, 1888, I find the following: "Peacock and Niemeyer have both given up the use of large doses of quinine. Quinine in large doses is unnecessary, useless, and often dangerous." That is strong language, but not too strong; and from the same paper, this: "Dr. Edeson says: 'For some years physicians have been quinine *mad*, affected with what may be termed *cinchoniphobia*. The practice seems to have been, when in doubt give quinine; give quinine any way.' How true this is! But we must not forget that this refers to the abuse of it. That it is a valuable medicine in some other than malarial cases, no one can doubt, even if we had no other proof than that given us by that most observant and experienced practitioner, Dr. T. Curtis Smith, in the MEDICAL AND SURGICAL REPORTER of September 16, 1882. Many of the people who write about malaria and quinine have had almost no experience with either of them. They jump to conclusions from the most trifling causes—fancy they have arrived at a knowledge known to no one else. Let me illustrate. An eminent physician, justly holding high rank as a careful observer and truthful reporter, was called to a young girl, and for two days thought she had worms, and treated her accordingly; but as she did not improve, he questioned her closely and discovered that, prior to her illness, she had been in Maryland. Then he concluded it was malaria, and he gave her 20 grains of quinine, and the next day chloral. She recovered at once. Then he published the case, with this heading: "Chloral as a remedy in Intermittent Fever." He had used before the chloral twice as much quinine as was sufficient to arrest an intermittent fever, but he disregarded that and credited the cure to a medicine which doubtless was entirely useless. This was read by thousands of physicians, and hosts of persons were, no doubt, dosed with chloral as a remedy for intermittent fever, or supposed malarial disease.

The abuse of quinine is beyond credence. A man has rheumatism, it is malaria; tooth-

ache, headache, indigestion, pains in the body, sleeplessness, irritative fever of any kind, carbuncle, catarrh, "kidney trouble," everything but pregnancy (and even every discomfort of that), is malaria. Recently I was told by an invalid, who did not look like one, that "his doctor said he was suffering from malaria which he had contracted three years before; that the doctor who attended him had not gotten it all out of him." I find it is a very prevalent belief with the masses that it is a difficult matter to rid the system of it. In that belief there is this comfort to physicians, namely, that if they be slow in giving relief the patients excuse them, because "we know it is difficult to get the malaria out of the system."

Within a month a friend of mine was in consultation with a physician who was dosing a young man with large doses of quinine, persistently day after day, despite fearful pain in the head, probably brought on by it, under the impression that he had malaria; when it was apparent to the consultant that it was typhoid fever, which copious hemorrhages from the bowels proved it to be.

In the *Medical Standard* of April, 1888, p. 113, is an article by I. R. Spooner, of Dakota, who says, speaking of "Pneumonia in Children," that after some preparatory treatment, "fifteen to twenty grains (quinine) should be given for one or two doses, then three to five grains, every three or four hours thereafter until temperature be reduced, when three or four medium doses should be given during twenty-four hours." He should have added if the child be still alive. All this, months after Dr. Ripley, the Drs. Jacobi, and four others had declared that their trials of it as an antipyretic had proven its utter uselessness in pneumonia. Just such treatment as is recommended by Dr. Spooner has been fashionable with many others, they believing that in large doses it would reduce the heat of the body, an opinion proven to be false by the observations and experience of Dr. Ripley and the five others who discussed the subject in New York and published their opinions in a medical journal.

It is fearful to subject a child to the dangers incident to these large doses of a medicine a few grains of which will make the head of an adult ring, and sometimes produce temporary if not permanent deafness.

—The *Boston Med. and Surg. Jaurnal* states that the Massachusetts General Hosptal has recently been given $50,000 by Miss Helen C. Bradlee, of Boston, as a memorial of her brother, the late L. Putnam Bradlee.

A NEW AND RELIABLE REMEDY FOR COCCYGODYNIA AND PRURITUS ANI.

BY R. STANSBURY SUTTON, M. D.,
PITTSBURGH, PA.

I have, for reasons I do not now care to speak of, regarded this disease as purely neurotic. I have treated it with the Faradic current. One treatment produces immediate relief; a few treatments cure it. Three cells are sufficient; time, five minutes; the frequency of application depends upon the return of pain. The anode is placed over the sacrum and the cathode in the vagina or rectum, or over the sphincter ani muscle. This treatment, so far as I know, is original with myself.

Much has been written of late concerning the treatment of pruritus ani. I desire to add my own suggestion. The best remedy I have ever found is the galvanic current; the quantity required need not exceed five milliampères; the time of application five minutes. The relief is immediate, and the application once or twice daily is quickly curative. The anode is placed over the perineum or base of the scrotum and the cathode against the sphincter ani, or, if required, within its grasp, bringing all the pruritic surfaces between the poles. I claim to be the first, so far as I know, to suggest this remedy for the treatment of this disease. I will ere long have more to say of it.

April 14, 1888.

FUNCTIONS OF THE MUCOUS MEMBRANE OF THE NOSE, THROAT AND EARS.

BY THOMAS F. RUMBOLD, M.D.,
ST. LOUIS, MO.

The mucous membrane is one of the important organs of the body. Upon it devolves functions that are so necessary to some of the phenomena of life, that without it life itself could not be maintained.

This organ is composed of an epithelial layer, a mucous membrane proper and a connective areolar tissue under it. In the epithelial layer are found compound or racemose glands, simple follicles and villi containing groups of blood-vessels in single loops and in net-work. Mucous membrane proper contains blood-vessels—the coats of which are encircled by sympathetic nerves, sensory nerves, muscular fibres and rounded enclosed follicles. The functions of the compound

and simple follicles are to maintain the surface of the mucous membrane in a moistened condition. The epithelial cells that compose the upper surface of the mucous membrane, contribute the same secretion, as also does each epithelial cell that composes the entire layer, as each cell acts as an independent secreting gland. It is seen, therefore, that the moistened condition of the mucous membrane is its normal condition. Please bear in mind that I said the *moistened* condition; I did not say a wet condition, that is, a condition in which the secretions are so profuse as to flow from one portion of the surface to another.

If the quantity of the secretion in the membrane is sufficient to form even a very slight stream, then we would have a flow, or by using another word which means the same thing, we would have a catarrh. It follows, therefore, that every mucous surface from which the secretions flow, even in the least quantity, has a catarrh of its surface. On the other hand, it is only when the mucous membrane is in a moistened state, and not in either a flowing or dry condition, that it is possible for it to perform, completely, the functions that are essential to health.

Some of the functions of the mucous membrane vary according to the location of the organ covered by it. In the nasal and pharyngo-nasal passages, the functions are to warm and moisten the air that passes through them into the lungs. As long as these peculiar functions are not interfered with, pathological changes of a very marked character may occur and the patient be unconscious of them. Even the special sense of smell may be so completely obtunded by inflammatory action, as to cause the patient to be unable to name even the week or month in which he lost the ability to recognize odors of more or less pungency.

In the pharynx the mucous membrane secretes a sufficient amount of mucus, to lubricate the bolus of food as it passes on its way to the œsophagus. If this function is not interfered with, the patient will be unconscious of the presence of a prolifierative pharyngitis, the favorite target of almost every throat specialist, and many general practitioners who take trouble to look at the throat.

In the larynx, trachea and bronchial tubes, the mucous membrane has little other function to perform than to maintain the surface of each organ in a moistened condition, but whenever there is a flow of mucus from either of these passages then they are in a catarrhal condition. In the air vesicles of the lungs, in addition to the maintenance of the surface in a moistened condition, its additonal function is to allow the entrance of oxygen into the blood, and the exit of carbonic acid gas from that fluid. When inflammatory action exists in this locality a flow of an excessive quantity of muco-purulent secretion is observed, the quantity being so great as to soon exhaust the patient.

In the Eustachian tube the ciliated columnar epithelia allow the gradual entrance of air into the middle ear, and thus maintain the normal rarefaction that is essential to normal hearing. In the middle ears and mastoid cells, its function is to absorb the air that enters these cavities through the Eustachian tubes, as without this air absorption we could not have perfect hearing.

In mentioning the uses of the Eustachian canal, all physiologists maintain that it is also a drainage-tube to conduct away the secretion of the cavity of the middle ear. This is an assertion that no one can prove. Most of these authors have forgotten that they had already stated in the first part of their works, that healthy mucous membrane secretes only that amount of mucus that is sufficient to keep the surface in a moistened condition. Besides this, the opening of the middle ear into the Eustachian tube is situated some distance above the floor of the tympanic cavity. In this respect, the opening between the middle ear and the Eustachian tube is similar to the opening of every mucous cavity of the head, such as the antrum of Highmore, the ethmoidal and sphenoidal cavities, the mastoid cells, and the frontal sinuses, in each of which the opening is as far away from the floor of its cavity as it is possible for it to be; and at the same time to be open from the side. If the opening into the left antrum of Highmore was made for the purpose of allowing mucus secretion to enter the nose, then each one of us would have to hold the head so far to the right side that the axis of the left auditory canal would be in a vertical line. To empty the right antrum an opposite position would have to be assumed. To enable one to allow secretion to flow from the sphenoidal sinuses, would require the head to be placed so far forward and downward that the forehead would be on a horizontal line. Even in this position these sinuses would not be entirely emptied. The same can be said of the ethmoidal cavities, and mastoid cells and frontal sinuses. The position which would be required to empty the left antrum of Highmore would not empty any other cavity of the head; while the position that would allow most of the fluid in the ethmoidal sinuses to

escape into the nasal cavities would be such as to retain all of the secretions in most of the other sinuses.

From this it is seen that in not one of these cavities is there a provision for the exit of mucus. Nature never intended that this secretion should be thrown off in the fluid form. It is all to either be evaporated or absorbed.

I think the reason why authors make the Eustachian tube an outlet for the middle ear, is because they find that this function is not inconsistent with the accepted theory of air entrance and exit. As long as they continue to hold to Toynbee's theory, which conceives it to be a canal through which air can pass either way, so long will they continue to consider it a drainage-tube also.

In treating all these passages and cavities, we must constantly keep in mind these varied functions and not interfere with them in the least if we expect to benefit the patient. In fact, it would be as much a fault on the part of the physician to treat one of these cavities without bearing in mind the functions of the membrane lining it, as for the surgeon to treat a fracture of the elbow without bearing in mind the function of this joint. If, in our applications we do anything to hinder this membrane from performing its functions, we shall aggravate instead of ameliorating the patient's complaint. This is the reason I do not use astringents or other irritants, as their effects on the mucous membrane are imcompatable with the performance of its functions.

We have in the inflamed mucous membrane an organ that has lost its functions, or rather is unable to perform these in a proper manner. Our duty is to restore the functions as soon as possible, and every application that will not assist in its restoration will certainly end in increasing the trouble.

We have inflammations of long standing, resulting in great changes in some portions of the membrane, as in the pharynx, which still are the cause of no inconvenience or disability to the patient. But if this same kind of inflammatory process takes place in some other organ, it may occasion a disability or the entire obliteration of some function. For instance, if the proliferation which we have seen in the throat occurs in the nasal passages that are normally small in calibre, it would compel the patient to open his mouth to allow respiration, thus helping to induce the follicular pharyngitis spoken of. If it occurs in the Eustachian tubes it would prevent the entrance of air into the middle ear; and, as this inflammatory process is slow, would be the occasion of that slow loss of hearing which we see in very many ear patients. If it occurs in the middle ear it prevents the ossicula auditûs from responding to the vibrations of the membrana tympani, leaving the patient more or less deaf. From this it is seen that a chronic inflammation may or may not be the cause of inconvenience or disability, and whether it is or is not will depend entirely upon the organ in which it is located.

SPASMODIC STRICTURE OF THE URETHRA FOLLOWING LABOR.

BY LLEWELLYN ELIOT, M. D.,

WASHINGTON, D. C.

The following is the history of a case which I attended recently, and is the first one of its kind with which I have met in fifteen years.

N. P., aged 23 years, born in Kentucky, of nervous temperament, but otherwise healthy, was delivered naturally of a male child, weighing nine pounds, at 12.30 on the morning of December 30. Her pregnancy had been marked by excessive gastritis in the earlier months, and by intercostal neuralgia in the latter, otherwise her health was good. On January 5, at 3 o'clock in the morning, she passed her water, but afterwards failed to do so. Hot applications were made over the region of the bladder, but with no relief; the pain and nervous excitement becoming very great, at seven o'clock in the evening I was called. With much difficulty a catheter was passed into the bladder, and a large amount of strongly smelling urine was drawn. On January 6, at 11 o'clock in the morning, the catheter was again introduced, but with pain and difficulty; at 11.30 at night a cocaine cone was allowed to dissolve in the vagina, the end resting on the meatus urinarius; the catheter was introduced and the urine drawn off; the pain was very severe and the stricture very tight; a soft rubber catheter was substituted for the silver one. On January 7, at 10 A. M., a cocaine solution, then a cocaine cone was applied, a soft rubber catheter introduced, and the urine drawn; pain severe and stricture very tight. At 9 P. M., an oleate of cocaine, 4 per cent., was applied to the urethra; after great persistence the soft rubber catheter was introduced into the bladder; the pain and nervous excitement

were so great that the catheter was clamped at the end and allowed to remain in place all night, directions being given to remove the clamp and allow the urine to pass at 1 A. M. and at 5 A. M. The catheter caused no inconvenience. On January 8, at 10 A. M., the urine was passed through the catheter, and the catheter then taken out. At 8 P. M., the catheter was introduced after much difficulty and severe pain and nervous excitement. On January 9, at 9.45 A. M., the catheter was introduced; the pain and nervous excitement and prostration following its introduction were so great that I determined to leave the catheter in the bladder, so, after clamping it, I gave directions to remove the clamp at 1, at 5, and at 8 P. M. The catheter was removed at 8.15 P. M. On January 10, at 10 A. M., the pain on introducing the catheter was not severe, and the spasm less marked. At 9 P. M. there was very little pain or excitement on introducing the catheter. On January 11, at 11 A. M., the introduction of the catheter caused no pain. On January 12, at 11 A. M., she urinated without assistance.

During the entire time of the spasmodic stricture the patient was taking the bromide of sodium and the bromide of potash, in fifteen grain doses every three hours, and the elixir of the valerianate of ammonia in dessertspoonful doses, but they did not appear to exert any influence on the spasm. In the beginning of the trouble I thought the urethral orifice might be irritated by the vaginal discharges, and to correct the acridity of them I ordered syringing the vagina with a solution of Tyree's compound antiseptic powder. This powder is a combination of carbolic acid, alum, borate of sodium, glycerine, the crystalline principles of thyme, eucalyptus, gaultheria and mint. While this solution had a most pleasing and soothing effect upon the patient it did not in the least affect the stricture. After the recovery of the patient, she informed me that her aunt suffered in the same way at her confinement; so there appears to be in this case an hereditary influence.

Stricture of the urethra occurs frequently after confinements, but if I can credit the unsupported statements of physicians, to whom I have mentioned my experience, they can not have the degree of persistence as in this case, or mention of it would have been made in text-books on obstetrics. While the four per cent. solution of hydrochlorate of cocaine has given me good results generally, I can not see why it should have failed me in this case.

Society Reports.

FRENCH ASSOCIATION FOR THE ADVANCEMENT OF SCIENCE.

SEVENTEENTH SESSION AT ORAN, ALGERIA.

(Reported by Arthur C. Hugenschmidt, M. D., Paris.)

First Day, March 29, 1888.

The seventeenth session of the French Association for the Advancement of Science opened on March 29, under the presidency of Colonel Laussedat, Director of the Conservatoire des Arts et Metiers, who delivered his opening address on "The Civilizing Influence of Science as Applied to Arts and Manufactures."

The Section on Medical Science, which is the one that interests us, had not so many members present as at the preceding meeting, which is certainly due to the choice as a place of meeting of the city of Oran, in Algeria, which is separated from France by about four hundred miles of sea. Many members remained at home, rather than risk a sea voyage, so that most of the men known by foreigners, or belonging to and characterizing French medical literature, did not appear. Amongst the members present were Prof. Verneuil, Drs. Blanchard, Delisle, etc. (Paris); Prof. Grasset (Montpellier); Gross (Nancy).

Section on Medical Science. — Honorary Presidents—Dr. Verneuil (Paris); Dr. Mondot (Oran).

President—Dr. Grasset (Montpellier).

Vice-Presidents—Dr. Cros (Oran); Dr. Fonteneau (Orán); Dr. Gross (Nancy).

Secretaries—Drs. Tinier and Bourdorim (Paris); Levy (Oran).

Second Day, March 30.

PROF. GRASSET, President.

Treatment of Diphtheria with Perchloride of Iron and Milk.

DR. MOHAMMED BEN NEKKACH (Inkermann), has treated twenty-one diphtheritic patients with perchloride of iron and milk, and has obtained twenty cures, and lost a child of six months. Among the twenty cured are two adults. All these diphtheritic patients have been treated from the beginning of the disease before the period of asphyxia or intoxication. Outside of these twenty-one patients, six others have died; two have refused to follow the treatment; one has been treated by another method in a neighboring town; a fourth one did not follow the treat-

ment accurately; and, finally, the two last are mere cases in which he was called too late by the parents. "To all these patients, most of whom were severely taken," he says, "I gave 25 to 30 gtts. of perchloride of iron in a tumbler of water (this solution being renewed every time it was used up); one quart of milk a day was given. A tablespoonful of each of these preparations was administered every five minutes. In addition to this medication, I have prescribed emetics and painted the throat three times a day with a strong solution of perchloride of iron, which, while taking away the false membrane, at the same time cauterizes the subjacent surface."

He states that when perchloride is administered from the beginning of the disease the false membrane does not extend, but the disease becomes localized.

Dr. Gibert (Paris), remains skeptical as regards the local action of perchloride of iron; he uses it as a tonic, but employs other agents in addition.

Curetting the Uterus in Endometritis.

Mme. Sarraute presents seventeen cases of curetting of the womb for this affection, with successful results. She uses the ordinary method, but with strictly antiseptic measures. She has remarked on several occasions that this intra-uterine treatment, while ameliorating or curing diseases of the uterus, had often a very beneficial influence on the state of the laryngeal apparatus, stopping its congestion and rendering the voice more clear.

Prof. Grasset (Montpellier), does not find it surprising that the laryngeal phenomena should have been modified after a uterine treatment, knowing the relations which exist between the genital and laryngeal apparatus, but he is disposed to think that the modified phenomena were nervous phenomena (paralysis or paresis of the glottis), instead of congestive phenomena.

Valvular Canula in the Treatment of Empyema.

Dr. Rogee (St. Jean d'Angely). After the operation of empyema we often have a small atrophied lung unfit for respiration, with or without a pleuro-cutaneous fistula, which must often be completed by Estlander's costal excision. M. Le Fort, at the last Congress of Surgery, asked whether it was not due to the fact that we leave the opening in constant communication with the exterior air, which freely penetrates into the pleura and presses on the lung.

I have done the operation for empyema twice and have had complete success in both cases. I attribute this success to the apparatus I am using, which prevents the exterior air being felt in the pleural cavity. This apparatus is composed of a canula with two valves, the action of which is a complex one. To these valves is due the fact that the compressed lung is obliged to dilate again. Every time the patient coughs the air contained in the pleural cavity is expelled but cannot return, and so little by little a vacuum is established, which obliges the lung under the intra-pulmonary pressure to expand towards the thoracic wall, while the thoracic wall itself has also a greater tendency to be compressed on the lung through the action of the pressure of the external air, which is no more balanced by the intra-pleural pressure.

On Israelite Circumcision.

Dr. Mondot (Oran), exhibited the *modus operandi* of circumcision as practiced by the Israelites. Having shown the instruments, he described the Jewish method. The first incision always produces a section of the skin, much inferior to that of the mucous membrane; then, instead of incising anew the mucous membrane of the prepuce lower down, the rabbin tears the mucous membrane vertically down to the skin in the median dorsal line. The mucosa of the prepuce is then turned down on the penis as the collar of a shirt. The dressing, which is composed honey and styrax, is then applied and kept there for six or seven days. The hemostatic method used is a primitive one, namely, suction of the cut parts with the lips of the operator. He has never met any cases of syphilis transmitted to the child by the mouth of the rabbin, when he performed suction.

Dr. Seguy (Oran), thinks that hemorrhage does not take place after circumcision as practiced by the Jews, on account of the tearing of the preputial mucous membrane. As to syphilis, it is such a common affection amongst the poorer classes of Jews in Algeria, and so much mixed up with scrofula, that it is a difficult matter to find out what really belongs to the child, or what might have been communicated to him by the rabbin.

Mechanism of Death by Decapitation.

Dr. Paul Loye said: Decapitation, as I have studied it, is very simple and very uniform in its *modus operandi;* it is the complete and rapid section of the neck at a certain level by a cutting instrument. The result ought then to be the same in every case,

placing the individual in an analogous condition, and bringing on death in a similar manner. Such, however, is not the case. If the operation is a simple one the lesions produced are very complex and show themselves as hemorrhages, asphyxia, excitations, paralyses, inhibitory and vasomotor phenomena, etc. The slightest difference in the stroke will produce a notable difference in the individual. I have found, for instance, great difference in a dog or in a man. In the dog we observe very extensive movements, general convulsions, in the head as well as body. In man, however, death is calm, without movements or convulsions; the physiognomy does not change, the body remains motionless. The difference is due to the fact that in dogs death comes with asphyxia. The blood which is left in the head or body can be no more oxygenized, nor get rid of its carbonic acid; moreover, the blood comes out rapidly and leaves the tissues without oxygen; these facts explain the convulsions of asphyxia.

In man these convulsions do not take place, because we have here another factor, the irritation of the nervous system described by Brown-Séquard, which brings on death by arrest, by inhibition. Under the influence of this irritation there is an immediate suspension or abolition of the reflex or auto-motor power of the spinal cord and nerve-centers; and if this auto-motor power is abolished, the asphyxiated blood can have no more action, produce no convulsions. It is also admitted, that in death by inhibition, there is an arrest of the exchanges between the tissues and blood; the blood remains red in the veins. We have then blood which does not become of the asphyxic kind, and on the other hand, nerve-centers which have lost their auto-motor excitability. Under these conditions there can be no convulsions nor general movements. The study of decapitation in dogs and men gives us an example of two types of rapid death. On the one hand asphyxia, accompanied by its convulsions; on the other inhibition—quiet death produced by an immediate arrest of all the functions of the body.

Dr. Vincent (Oran), asked the reason of this difference in the mechanism of death between men and dogs? In the man who is guillotined, he thinks that the weight of the knife striking the neck produces an intense cerebral commotion, which is not experienced by the dog which is killed in a laboratory.

Dr. Love does not admit this reason, for if there is cerebral commotion, signs of asphyxia would be present in the rest of the body.

Dr. Moreau (Algeria), thought this difference might be explained on the ground that man knows beforehand what will happen, while the dog is absolutely unconscious.

Dr. Milliot (Bugeaud). It is said that in decapitation section always occurs at the third or fourth vertebra; this is a great interval. In such a region it is necessary to be more precise, and to know centimeter by centimeter what a lesion can produce.

Dr. Love, in answer to Dr. Moreau said, that he had seen two men just before their execution by the guillotine; one was most frightened and terrible to observe, the other was perfectly calm; both presented the same phenomena after death. In answer to Dr. Milliot he said, that certainly a centimeter is important, but that his line of section had passed between the first, second, third to the seventh intervertebral space, and all gave him the same result.

Prof. Grasset thanked the author for his most interesting communication, but said he was an unbeliever in the inhibition theory of death.

Special Deformity of the Hands of Glass-makers.

Dr. Rollet (Lyons), draws attention to a special deformity he has observed in glass-makers, who have been at work for several years. There is a permanent flexion of the second phalanx on the first, specially the ring finger. At the beginning there are no signs of muscular atrophy or subluxation, which later render the disease almost incurable. This hook-hand is peculiar to glassmakers who handle the cane; it is a spasmodic contraction of reflex origin. It is an entirely different lesion from the contraction of the palmar fascia.

Dr. Grasset regards this as another example of professional spasms; it is, he says, a new element for the study of peripheral amyotrophies. It begins by a simple contraction, then ensues a neuritis, and finally muscular atrophy.

On a New Form of Painful Arthropathy.

Dr. Poncet (Lyons), draws attention to a new form of arthropathy, which is characterized by continuous violent articular pains, which have appeared in a long diseased articulation, without any apparent causes or complications. "I have made," he says, "three observations, in all of which the patients had been affected for several years with old arthritis of the knee and hip-joint; twice the articulation had suppurated, but fistulous tracts persisted, and it was only after fifteen or twenty years that pain supervened."

In one case, a young woman, 27 years old, of neurotic temperament, for the past ten years had walked on crutches. After having etherized her, I straightened the limb and applied superficial irritation with the thermo-cautery, and then applied a silicated bandage. The patient as soon as she recovered from the ether complained of terrific pains in her knee and corresponding extremity. I gave her morphia injections without relief, and during the night I had to open the bandage, but the pain remained the same, and kept on for some time. At the end of three weeks she suffered a little less. Since then, five years after my interference, the articulation has always been the seat of pain coming on at irregular times. The extremity is atrophied, and as soon as she touches the floor with her feet she gets those fearful pains.

In two other patients who were suffering a very great deal, and whose limbs became useless, I performed amputation. One of them died after disarticulation at the hip-joint, necessitated by the atrocious pain she complained of in the whole lower extremity and coxo-femoral articulation. In the last case, a woman, 36 years old, who had had for eighteen years a suppurating arthritis with fistulous tracts, was taken with severe pains in 1883. I saw the patient two years afterwards, and tried in every available way to procure her relief. Not succeeding, I amputated the lower third of the thigh. From that moment the pains ceased, and have not re-appeared for more than two years after the operation.

This arthralgia develops itself in old articular lesions not yet cured, and of variable nature. From our observations, the articulation of the knee seems to be predisposed to it; and this form of neuralgic arthralgia seems to be found exclusively in women. The prognosis is a very doubtful one, no medical treatment appearing to be of any use. The surgical intervention must be a radical one.

Antipyrin, Antifebrin and Solanin.

Dr. Sarda (Montpellier), communicated a paper on antipyrin and antifebrin in nervous disorders, and compared them with solanin. He had made one hundred and thirty observations. The first two drugs are excellent nervous sedatives; but they have not an absolutely parallel action; antipyrin is very useful in acute articular rheumatism, in hemicrania, and neuralgias of recent date; in all these cases the superiority of antipyrin is undeniable, as it is also in paroxysmal pains of any nature.

Antifebrin is inferior to antipyrin when it is necessary to combat the above-mentioned pains; it is as good as the former in ataxic pains and chronic rheumatism. In neuralgias of long standing, the superiority of antifebrin is certain.

Against excito-motor phenomena, epileptoid trembling, exaggerated reflexes and tremors, antipyrin gives unsatisfactory results; it has given no great success in reflex spasms of hysterical patients, and has given negative results in painful facial tic. In all these cases, with the exception of paralysis agitans, antifebrin is much better. These two drugs are very rarely followed by accidents, such as vomiting, exanthemata, profuse sweats. Antifebrin is the better supported by the stomach.

Solanin is a nervous sedative which is very useful whenever one wishes to have a depressant action on the spinal cord or medulla; it produces a paresis of the motor nerves, and anæsthesia of the sensitive nerves. It is not efficacious in acute articular rheumatism; it is very useful in muscular rheumatism; acts as well as antifebrin to allay the pain in gastric ulcer, as three of my observations show. It is much superior to both antipyrin and antifebrin in the treatment of old and persistent sciatica, especially in cases of neuritis. It has also an excellent action in ataxic pains. Solanin is a most precious drug as a moderator of motor excitation. Out of two cases of chronic myelitis with fulgurating pains and epileptoid trembling the results have been remarkably rapid and constant. Pain and tremor have been suppressed. In a case of sclerosis in patches with very extensive tremor of the left upper extremity, the results have been still more remarkable; after four days treatment the tremor had almost disappeared, and did disappear completely on the sixth day. In paralysis agitans, painful facial tic, post-hemiplegic hemiathetosis, the results are less certain; but the doses have been too small to allow us to doubt the efficacy in these last cases. The average dose is 5 to 6 grains in the twenty-four hours.

Dr. Grasset said: I insist on the therapeutic value of solanin, which has, however, one objection: it costs two dollars for every 15 grains. It is specially used in medullary symptoms produced by lesions of the lateral column. It is very useful against epileptoid tremors and tremors of sclerosis in patches.

Mycosis Leptothrix of the Pharynx.

Dr. Moure (Bordeaux). Mycosis of the pharynx was described for the first time in 1873, by Fränkel, of Berlin. It is a

very common affection, much more so than is thought, and I myself have given up the record of these cases. The etiology, very obscure, is like all the non-diathetic chronic affections of the pharynx. The functional symptoms may all be missing; they are habitually those of granular pharyngitis. On examination you find, on the tonsils or base of the tongue, little tufts projecting above the mucous membrane; they are sometimes uniform or irregular on their surface, yellowish white in color, and detached with difficulty on account of the penetration of the parasite into the mucous membrane. In an anatomico-pathological point of view, these white tufts are composed of leptothrix buccalis. Inoculation of the same have given negative results. The treatment consists in extracting the tuft and cauterizing the point of implantation with chloride of zinc or lactic acid, or better with the thermo-cautery or galvano-cautery. Hering has found in one case in which he extirpated the tonsil that the parasite had penetrated to the extent of one-third of an inch. This affection has no general symptoms; it is very much like granular pharyngitis. No diathesis seems to favor the appearance of the disease.

Effects of Hydrofluoric Acid in the Treatment of Diseases of the Respiratory Passages.

Drs. Moreau and Cochez (Algeria). Of sixty patients in whom they have employed this treatment, twenty-eight have been ameliorated, four remain in a stationary state, nine have grown worse, four died, eleven disappeared after the first or second consultation, four suffered only with asthma and chronic bronchial catarrh. If this method is not an absolute cure, it is useful and has never appeared useless. We must, however, determine which cases are more apt to derive benefit from this treatment. Hydrofluoric acid appears to act by exciting the appetite, modifying the nature of the bronchial expectoration, and probably in destroying the microbes and their infectious products in that secretion, and possibly in the pulmonary tissue itself. The inhalations are well supported, produce no conjunctival irritation, but a little irritation of the teeth.

Dr. Laussedat said that at Cannes, Dr. Chuquet, who had been experimenting, had found that all non-advanced tubercular patients were stimulated by inhalations of hydrofluoric acid; he saw their appetite return, but he had never seen the cavities in the lungs beneficially influenced. He has also observed that those patients who had, and those who had no cavities, always had Koch's bacillus in the sputa in the same proportions.

Dr. Love thinks the anti-microbe action of this acid is not demonstrated. He also does not believe in those very difficult and complicated ways of establishing inhalation-rooms for the treatment with this gas.

Third Day, March 31.

President, Dr. Grasset.

Dr. Pauly (Oran), read a paper on

The Algerian Climate; Resistance of the Algerian Cattle to Certain Contagious Diseases.

Dr. Brémond (Oran), read a paper, giving an account of the resistance of the Algerian cattle to malignant pustule and sheep-pox. He then demonstrated that immunity is acquired and lost according to the conditions of living.

Prof. Verneuil (Paris). The question of immunity is a very contested one; one ought to enquire whether immunity is not due to the fact that the animal had already contracted the disease while very young, or perhaps, that it is issued of parents already vaccinated or which had suffered from the disease. It would be an interesting fact to follow a bull which may have been spontaneously cured and search whether his descendants are also preserved from anthrax. Another question interests me, the one of latent microbism. When a bull has been cured I would like to have him under observation for months, and have his blood accasionally examined to see how long convalescence persists; for we know that if a vaccinated bull several weeks after this operation wounds himself, at the wound *minoris resistentiæ*, appears sometimes an anthrax tumor. In human medicine we have similar facts: a man cured of typhoid fever is apparently well; for one reason or another he gets an abscess; if you open it you will find in it the microbe of typhoid fever.

Abnormal Forms of Cancerous Cells.

Dr. Nepveu (Paris). I desire to draw your attention to certain rare cellular forms, which I have met in certain epitheliomas of the tongue and penis. In all these cases the epithelioma had invaded the deep tissues and the glands themselves.

The first type consists of small, nearly round cells, epitheloid, with one or two very fine prolongations, equalling one, two, four, five times and more the diameter of the length of the cell; which prolongations terminate sometimes by a free extremity, at other

times by a finely granular swelling, fusiform in appearance, sometimes terminating on one of the irregular borders of an epithelial cell of large volume.

A second type, which the author has termed conjugated, is a little different. The cell instead of being round is oval, with a rounded head; one single prolongation longer than the preceding one presents a fusiform swelling in the middle of its length and at the extremity of a break at the point of insertion on a neighboring cell. The clearest forms are those in which two cells, clearly epithelial, are united by a more or less long prolongation. Some of these conjugated cells are of different types. Some are irregular and show at their angles very fine ramifications; the others are very large flat cells, although also fusiform. One can see the polygonal cells united by a prolongation to one of these flat cells.

It is not rare to see epithelial cells presenting three or four prolongations, which it has been impossible to follow in all their extent; but everything makes me think that, like the others, they are united to other cells. In a word, in deep epitheliomas, one can find epithelial cells with ramified and multiple prolongations like the multipolar nerve cells. These prolongations unite epithelial cells to each other. These cells called conjugated, are formed sometimes by young cells united to an old, well-developed one; sometimes by well-developed cells united to each other. In certain cases it appears that these epithelial cells are united to fusiform but flat cells, analogous to certain cells of connective tissue.

Tuberculosis in Those Living at Mineral Springs.

Dr. Laussedat (Royat) finds that, while tuberculosis was very rare at Cannes twenty-five years ago, it is at present very common, especially in children and young people, without one being able to trace it to heredity. This is especially due to the dissemination of the tubercle bacillus brought there by tubercular patients. Hence it becomes necessary to have the schools kept absolutely clean, and the furniture which has been used by phthisical patients thoroughly disinfected, or even destroyed.

Intra-venous Injections of Salt-water.

Drs. P. Loye and Dastre. If one injects into the veins of a rabbit salt-water containing 7 gms. of chloride of sodium for each 1000 gms. of water, one can, on following certain indications, throw into the circulation an indefinite quantity of liquid, equal to, and even greater than the weight of the animal. The most important fact is that the injection should be made in a definite manner, not more than 2 grammes being injected per minute for each kilogramme of the animal's weight, and that the liquid should have a temperature of 102° to 104°. Under such conditions we find that there exists in the organism a real regulator apparatus for the quantity of water in the blood. Every time that in a rabbit weighing three kilogrammes, you inject into the blood 300 gms. of salt-water, the animal will urinate; and then, if the injection is continued, the animal continues to urinate, keeping in his circulatory apparatus the same quantity of 300 gms. of salt-water. From this fact there is a regular parallel between the number corresponding to the injection of salt-water and the number indicating the emission of urine. Gradually the urine loses its turbid and yellow appearance and becomes absolutely clear. You can in this manner, allow the passage into the circulation of an indefinite quantity of water. During all these operations, the blood pressure is not changed.

If you put more than seven grammes (2 drachms) of chloride of sodium to a litre (two pints) of water, you get a temporary glycosuria. The injected liquid remains in the blood, the aqueous portion of the same being then increased. He has also never noticed any bad effect on the kidneys.

Dr. Grasset. These injections might help us to increase diuresis, and a washing out of the blood. This is what we do when we give large enemas of water to patients with jaundice. The water is absorbed by the intestines, thence taken into the vascular system, and is finally rejected by the kidney loaded with bile.

Experimental Researches on Submersion.

Drs. P. Loye and Brouardel. If a dog be suddenly plunged under water he will die in three and a half to four minutes. He first takes a very deep inspiration, called "surprise inspiration," which fills a great portion of the respiratory passage with water. Sometimes a second inspiration will take place, then the period of resistance appears, the animal has stopped inspiring. This lasts a few moments, and is accompanied by general movements. Then he begins to inspire again and the movements stop. Finally, respiration stops, sensibility is lost, and the animal is dead. If we observe the circulation, we will find the heart's movements diminish one-third or one-half, but the strength of each beat is increased as well as the blood-pressure, and they remain so until death; the beats are sustained, but the blood-pressure decreases gradually until the last inspiration is taken,

when it is down to zero. The heart, however, will still continue to beat for about fifteen minutes after the last inspiration, the blood-pressure remaining at zero. The period of resistance which follows the deep inspiration is not due to the will, for we find it in tracheotomised dogs, but is due to an action on the superior laryngeal nerve, which brings reflexly into action the respiratory nerves. The water introduced into the lung will help to dilute the blood, before and even after death. The legal physician who is called to determine whether a drowned person was alive when thrown into the river, or if he was already dead, tries to get his information from the state of the blood as to its being coagulated or not. He concludes that death occurred by submersion if the blood is found liquid. But we have just seen that water will pass into the circulation after the patient is really dead, and that even in drowned persons the blood will be found coagulated if examined soon after death; the blood will also be found liquid in the large vessels and right heart.

On the Use of Biniodide of Mercury in Surgery.

Dr. Rogee (St. Jean d'Angely), claims for it that it does not irritate the wounds. It is a much stronger antiseptic than carbolic acid, and an alcoholic solution of 1 to 300 can be mixed in all proportions with warm water. It is much less expensive than Lister's dressing. He has used it in 108 operations, 32 being major operations, with one death. On an average, cicatrization was obtained in seventeen days after an amputation of the thigh in a malarial patient, and in ten days after herniotomies.

Spinal Meninges in the Sacral Canal, and the Filum Terminale.

Dr. Trolard (Algeria). The classical authors give as terminations of the dura mater and arachnoid, *cul-de-sacs* at the end of the sacral canal. Even in children this *cul-de-sac* stops on a level with the second sacral vertebra, the canal from this point being filled with nerve branches and a great deal of adipose tissue. A fact worthy of notice is that the ganglions of these nerves are situated in the canal itself. As to the filum terminale, it is probably the common trunk of the two last pairs of spinal nerves; if one examines it carefully he will find that it is divisible into these nervous branches, but its termination is very variable.

Lakes of Blood of the Dura Mater.

Dr. Trolard describes them as follows: The veins which open into the superior longitudinal sinus are described as opening into that canal in a direction contrary to the blood current. This is not quite true. The little veins, especially the anterior ones, open directly, or from before backwards, into the sinus. As to the two or three large veins, they communicate with the sinus from behind forward. But one must not overlook the fact that these anastomotic veins place in communication the superior longitudinal sinus with the superior petrosal and lateral sinuses. These anastomotic veins which are accessory to the great sinus must have the same direction that this last one had.

Reports of Clinics.

HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA.

MEDICAL CLINIC—PROF. PEPPER.

Lithæmia With Grave Nervous Symptoms.

The patient is 29 years of age, a physician by profession, having graduated from the Medical Department of the University of Pennsylvania in 1885. His family history is remarkable for the singular unanimity with which all its members are disposed to disease of the same organ—the kidney. His father and mother were both of a markedly nervous diathesis; throughout their lives they both exhibited a strong tendency to renal troubles, and, finally, both of them died of Bright's disease. An uncle was afflicted with *petit mal*, and three brothers and a sister of the patient have all, without exception, gout and gravel. While yet a child, he had an eclamptic seizure produced by the passage of some renal calculi. Speaking generally, however, such attacks in childhood have but trifling significance, slight causes being sufficient to produce them.

The patient has always been rather sickly, and yet, in spite of his want of bodily vigor, he has been a hard-working and faithful student. He pushed his way through the University of Virginia, and subsequently came here and graduated in medicine. Eight or ten years ago, while he was still pursuing his studies in the South, he first became aware of the fact that occasionally on awaking in the morning his tongue was more or less lacerated around the tip and edges, as though it had been bitten. About this period, also, he began to have irregular attacks of nervous prostration and violent headaches, which were relieved only by free

purgation. During his term of study in this city, he was an almost constant sufferer from nervousness and lithæmia, being treated at odd times for gravel, sciatica, insomnia, etc. He was told by his room-mate while here of the occurrence of nocturnal epileptic seizures, and in these was found an explanation of his wounded tongue. During the last few years the symptoms of renal trouble have become much more prominent. He is not conscious of having passed any calculi for a very long time, but he complains of severe and continuous pain originating over the region of the right kidney, extending down the ureter of that side, and thence along the course of the genito-crural nerve in the groin and to the bottom of the testicles and scrotum. As often as once or twice a month a sudden exacerbation of this pain precipitates a series of convulsive paroxysms which are most violent. The muscular contractions attending them are tonic in character and limited usually to the right side, the leg and arm being drawn up and held rigid for five minutes or more. Then there is a period of relaxation, lasting generally for about twenty minutes, and this is followed by a recurrence of the spasm. A series of these phenomena may endure for a few hours only, or continue throughout two days. During such attacks there is no loss of consciousness, but the patient says he feels as though he would become insane at times from the agonizing pain that accompanies them. Within a comparatively recent period, also, he has had four epileptiform seizures, *petit mal*, occurring in the daytime, and characterized by a very transient suspension of consciousness, a momentary fixation of his eyes, and slight twitching of some of his muscles.

Examination of the urine shows it to be typically gouty in character. It is of high specific gravity, acid in reaction, high colored, and loaded with urates.

We have here, then, a long and connected history of renal derangement occurring in a man the members of whose family are all strongly disposed to kidney complaints as well as to various neuroses. His disease is inherited; it first gives evidence of its existence in early childhood, and it continues and gains strength with advancing age. When about 19, the patient begins to have attacks of nocturnal epilepsy, occasional fits of nervous prostration, severe headaches, etc. In spite of these difficulties, however, he continues his studies, graduates from college, and enters upon the practice of his profession. At this time we find his symptoms becoming of a mixed character. In addition to the nocturnal epileptic seizures, he has several attacks of *petit mal* in his waking hours, and, besides these, on two or three occasions he tells us, prolonged periods of unconsciousness, without, however, any convulsive phenomena. These latter are known by the name of "status epilepticus." Moreover, the symptoms of urinary disturbance take on increased energy; he suffers from constant pain over the right kidney and in the right groin. Once a month, or perhaps, oftener, this pain undergoes a sudden and intense aggravation, and, at such times he has simultaneous attacks of right-sided convulsive seizures, and, sometimes, when the pain is unusually severe, the arm of the left side participates in these movements. These seizures are in the highest degree interesting and curious. They are certainly not epileptic for throughout their entire duration, be it brief or prolonged, perfect consciousness is maintained. To such attacks as these is given the name of "hemi-spasm." Their occurrence is ascribed to the irradiation of powerful motor impulses proceeding from nervous centres, which are kept in an almost constant state of irritation and excitement by the morbid condition of the blood which nourishes them. From time to time there occur periods when defective coordination between the great abdominal viscera, the kidneys, liver, and stomach, is followed by serious vitiation of the blood. The processes of secretion and excretion are interfered with or temporarily suspended, and the blood becomes loaded with effete products which, when in sufficient quantity, quickly manifest their power of exerting an actively poisonous influence. The nervous centres, bathed in this toxic fluid, become intensely irritated, they become even more morbidly sensitive than usual, until, finally, when nervous tension has reached a point beyond which it cannot go, there is a sudden explosion of force manifesting itself in these violent muscular contractions. At such moments comparatively slight causes are sufficient to overthrow all inhibitory influence, and give free rein to these irregular exhibitions of energy. In this particular case, these phenomena are brought out with exceptional clearness.

Now, after this hurried rehearsal of the more important points of the case, we have to ask ourselves first, What is the source of the intense pain which precedes and gives rise to these attacks of hemi-spasm? During the periods when it is present, it is too persistent in character to be regarded as neuralgic. Upon considering the region from

which it takes its origin, and the course over which it travels, our attention is strongly attracted to the right kidney. As I review in my mind the history of this man's sufferings, his undoubtedly gouty diathesis, the many significant symptoms he presents of renal disorder, and the frequent and severe reflex disturbances which have that region for their starting-point, I am led by the mass of accumulated evidence, to believe in the existence of calculous deposits in the substance of this right kidney. The calculi are certainly not contained in the pelvis of the kidney, because urinary examination negatives the existence of pyelitis. I am the more strongly inclined to put faith in this diagnosis, because I remember with painful distinctness, an obscure case, closely resembling this in many of its leading features, in which the autopsy disclosed a number of calculi disseminated throughout the substance of one kidney. In case, therefore, other methods of treatment should fail to give this patient relief, I shall strongly urge upon him the propriety of having his suspected kidney removed.

Preparatory to any resort to surgical measures, however, I shall put him upon the following plan of treatment: In the first place, to obtain a strong and continuous counter-irritant effect, we will establish an issue over the diseased organ. Second, a powerful galvanic current will be passed at intervals through the centre of the area of disturbance. Third, a plan of diet will be adopted which will largely diminish the formation of uric acid, and of which milk and cereals will be the principal components. Fourth, and last, a course of bromides will be prescribed by which 7½ grains each of the potash and soda salt will be administered three times daily.

In addition to these more important points of treatment, a system of graduated and regular exercise will be carried out, which will prove of much assistance, not only by improving the patient's general health and vigor, but by diverting his mind and preventing it from dwelling upon his malady.

—A physician in the *American Magazine*, illustrating the evil custom of talking to an invalid about his pains, says that once he requested a mother to mark a stroke upon a paper each time that she asked a sick daughter how she was. The next day, to her astonishment, she made one hundred and nine strokes. A three months' visit away from home was prescribed.

Periscope.

The Antiseptic and Antipyretic Treatment of Phthisis.

Dr. W. H. Spencer, Lecturer on Medicine, at the Bristol Medical School, England, in the report of some cases illustrating the antiseptic and antipyretic treatment of phthisis (*British Med. Journal*, January 28, 1888), speaks as follows with reference to the use of iodoform and eucalyptol:

"1. I see no reason to doubt that, when iodoform is given in doses which the stomach will tolerate well, and given frequently and continuously for long periods, it is absorbed into the circulation; and in the lungs, in whatever form it be, manifests its antiseptic (shall I also say, antibacillary?) properties. The good effects of iodoform so administered, in phthisical conditions, is too unequivocal to be gainsaid.

"2. I see no reason to doubt that, when the vapor of the oil of eucalyptus (or other antiseptic vapor that can be tolerated equally well) is inhaled continuously and for long periods, it reaches the residual air in the lungs; and so externally, as it were, bathes the affected tissues, or suppurating cavities, which may be open to the ingress of the air.

"3. That so, I apprehend, we may have antiseptic remedies, not antagonistic, brought up on two sides to the sites of inflammatory lung lesions, or the sites of bacillary activity; and these antiseptics, mutually co-operative, do affect for good both the inflammatory process and the bacillary activity, and bring about repair by the mode of organization after suppuration or fibroid substitution.

"4. And further, let me say, that I think it is both correct and desirable to treat the pyrexia of acute phthisical processes, whether the temperature be high or moderate, by and for itself. I think no other special antipyretic than quinine should be used in phthisis; and quinine serves other purposes as well when used as an antipyretic in moderate doses." He sums up the whole of his paper in some remarks on what he conceives to be the practical outcome: "In our treatment and general management of these cases, it is our aim to promote or bring about healing of the damaged lung tissue, and this by means of fibroid substitution. In order to attain this end, we must secure the same conditions and adopt similar measures, if we can by any means compass it, to those we find successful in dealing with suppurations, ulcerations, and the like lesions, in parts exposed to view. To secure these conditions, we should adopt measures for supplying adequate nutrition—

that is, adequate anabolism of tissue and the storing of energy—in the body generally, and in the damaged part in particular. We should deal with pyrexia on its own account, as a general and constitutional state, apart from the local suppuration or ulceration (as by quinine). We should bring the lesion under the influence of antiseptic remedies, both by internal medication (as by iodoform), and by external applications (as by inhalations of eucalyptol); and the application and influence of the antiseptic should be complete, continuous and prolonged."

Simultaneous Presence of Cancer and Tuberculosis.

In *Virchow's Archiv*, Bd. cxi., Heft 2, Feb., 1888, Dr. Otto Lubarsch, of Breslau, in a communication upon primary cancer of the ileum with some remarks upon the simultaneous occurrence of cancer and tuberculosis, concludes that:

1. The relatively infrequent occurrence of cancer and tuberculosis in the same person, is not adequately explained by reference to the different periods of life during which these two diseases are most frequent.

2. It is not true that cancer of a particular organ, such as the œsophagus (Lebert) predisposes to tuberculosis.

3. Acute infectious diseases, as well as phthisis, are proportionately much rarer in patients with carcinoma than in non-carcinomatous patients of the same age.

4. Tuberculous affections, as well as chronic local wounds, may favor the development of a cancer.

Spontaneous Expulsion of a Fœtus after the Death of the Mother.

In the *Deutsche med. Wochenschrift*, December 15, 1887, Dr. Theopold says that during the inspection of the dead body of a woman, the fœtal head surrounded by the membranes was expelled from the vulva. This statement was sent to him for his *superarbitrium*. The woman, who was far gone in pregnancy, had died of hemorrhage. The neighbors, who had been summoned by the husband, found her dead. The corpse had lain fourteen days in the grave, and was exhumed on a hot day in August, and had been exposed some time to the open air. The belly of the woman was greatly puffed up with gas. Evidently the pressure of the gas, the tension of which had been raised by the heat, had expressed the contents of the uterus.

The suspicion that the husband had ill-treated his wife and so caused her death led to an official autopsy, and the disagreement of those who conducted this autopsy to the giving of a *superarbitrium*. It was assumed in the latter that birth had begun and that premature separation of the placenta had been the cause of the fatal hemorrhage. As the autopsy did not reveal definite traces of the woman having suffered ill-treatment, and as there were no witnesses to any, proof of a crime could not be adduced.

Complex or Vertical Hermaphroditism.

At the meeting of the Pathological Society of London, Feb. 21, 1888, Mr. Stonham exhibited a case of complex or vertical hermaphroditism. The child had been operated upon for hernia, and the contents of the sac were returned to the abdomen; the wound suppurated, and the patient died. The external organs were of the male type, with undescended testes; the bladder was normal in size and shape, and its neck was surrounded by a prostate. Behind was a vagina and uterus, the latter being devoid of a projecting external os, but having a distinct cervix. On each side of the uterus were testes, and below them Fallopian tubes and epididymis. The family history was interesting, one sister having a bifid nipple, and two brothers each a well-formed penis and scrotum, but no testes. Mr. Sutton thought the case proved that the prostate was homologous with the cervix uteri. Mr. Jonathan Hutchinson Jr., opposed this view.—*Lancet*, Feb. 25, 1888.

Tumor of the Stomach produced by Hair; Gastrotomy; Recovery.

John Berg, who reports this case, states that the patient was a married woman, twenty-six years old, who had suffered from the third year of her age with dyspeptic and anæmic symptoms, but especially with vomiting of mucus. A tumor in the epigastrium had become evident since her tenth year, and had developed rapidly during the past six months. She entered the hospital in Stockholm in May, 1887. At that time there could be felt in the epigastrium and in the left hypochondrium, between the prolongation of the right parasternal line and the left mammary line, a tumor the size of a hand, movable, and having a concave superior and a convex inferior border. The tumor could not be displaced toward the region of the kidneys. The spleen was in its normal position. Laparotomy was performed, and in the stomach was found a tumor, which consisted of a bunch of hair.

The patient denied having ever eaten hair, but her mother said that when three years old she was in the habit of chewing and swallowing hair.—*Nordiskt med. Arkiv*, Bd. xix., No. 26, 1888.

Washing out the Pelvis of the Kidney and the Ureters through the Bladder.

In a communication in the *Lancet*, March 10, 1888, Mr. Reginald Harrison refers to the possibility of distending the ureters with fluid, and thus reaching the pelvis of the kidney. In the normal condition of the parts such a process could be brought about only by very gradual means, as the mode of entrance of the ureters into the bladder is such as to render sudden regurgitation of fluids from the latter toward the kidneys well nigh impossible. But in long standing stricture and prostratic obstruction, this valve-like arrangement becomes impaired until the ureters and pelvis of the kidney become little else than subsidiary bladders. The same thing occurs as the result of the passage along the ureters of calculi and suppurative *débris*, as is frequently seen in tubercular disease of the kidneys. It occurred to Mr. Harrison that when such conditions exist fluid might be made to pass from the bladder along the ureters to the pelvis of the kidney. The author then refers to cases in which these theoretical considerations were put to a practical test. In all these cases renal calculi, or fragments of them, were successfully dislodged from the ureters by distending the bladder with fluid.

Treatment of Ranula.

Verchère recommends in the *Archives de Laryngologie* the treatment of ranula by puncture and injection of a ten per cent. cocaine and a one-tenth per cent. chloride of zinc solution. The tumor is punctured with a Pravaz's syringe and emptied by aspiration. The canula is left in the sac, into which is then injected half a syringeful of a ten per cent. solution of cocaine, followed by ten or twelve drops of a one-tenth per cent. solution of chloride of zinc in distilled water. The inflammation which follows is usually not very violent, and recovery is rapid. In the place occupied by the ranula there remains a small nodule, which occasions no disturbance.—*Wiener med. Presse*, March 25, 1888.

Quinine Amaurosis.

Dr. Edgar Browne (*Liverpool Med. Chir. Journ.*) points out the difference between quinine and tobacco amaurosis. Alluding to a case of quinine amaurosis, he says: "The ocular symptoms in this (and other recorded cases) are very remarkable. After an interval of total darkness, recovery commenced by a rapid restoration of central vision, the peripheral retina remaining quite useless both for form and color. The movements of a flame can be perceived all over the field, but not those of the hand or any non-luminous object. Within the central area vision is practically perfect. The patient sees as through a small hole clearly, but nothing above, below, or to either side of him, and as a consequence, though he can read the smallest print, he runs against lamp-posts and upsets people in the street in the most amazing fashion. The condition is exactly opposite to that observed in tobacco (or central) amblyopia, where the patient cannot read print but is able to move about crowded streets, to ascend the rigging of a ship, or avoid vehicles with little or no diminution of his accustomed facility."—*Medical Chronicle*, March, 1888.

Weil's Disease.

In the *Deutsches Archiv für klinische Medicin*, Bd. xlii, Heft. 4, Dr. A. Fiedler gives the following summary of this disease, which was first described by Weil in 1886: It is an acute infectious or toxic disease which has nothing in common with abdominal typhus nor with any other known disease, but is a disease *sui generis*. It begins quite without premonitory disorder, and often suddenly, with a chill. Symptoms always present are fever, headache, gastric disorder, jaundice and muscular pains, especially in the peronei. The fever has a typical course and continues from eight to ten days. Occasionally after the fall in temperature, which takes place gradually, a relapse of the fever occurs. The pulse at the beginning of the attack is frequent, but subsequently becomes sub-normal. The spleen and liver are frequently, but not always swollen, and the liver is often tender upon pressure. Nephritis is frequently present, and at times herpes and erythema. The prognosis is generally favorable. It attacks especially men in the prime of life, and appears preferably in summer. The bearer of the disease is still entirely unknown; but the circumstance that among twelve male patients nine were butchers, makes it probable that men of this occupation are affected in a higher degree, or more easily, by the noxiousness which causes the disease, than are other persons.

—Dr. Schiefferdecker of Göttingen has been appointed prosector of anatomy in the University of Bonn.

THE

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THE SYMPTOMS AND TREATMENT OF HERNIA OF A MUSCLE.

The occurrence of a protrusion of a part of a muscle through an unnatural opening in its sheath has been recognized for many years, and it is known in works on surgery as hernia of a muscle. It has sometimes been confounded with rupture of a muscle; but when correctly understood, the term applies solely to what we have described above. The subject has been well studied by Farabœuf, about seven years ago, and most recently by DR. AIMÉ GUINARD, of Paris, who reports the results of his study in an interesting paper in the *Gazette Hebdomadaire*, April 6, 1888. In this paper Guinard points out the errors contained in most descriptions of this injury, and gives an explanation of its phenomena which is entirely consistent with the mechanical conditions which must be present. The most conspicuous error in the previous descriptions consists in the assertion that the tumor caused by hernia of part of a muscle increases in size when the muscle contracts. In order to get at the truth in this matter Guinard made a number of experiments on living animals, and found that after removing part of the sheath of a muscle, there was no hernia when the muscle was inactive. When the usual action of the muscle was imitated by force, and it remained inactive, there was a protrusion. This protrusion disappeared when the muscle was stretched by an action opposed to its own. It disappeared also when the muscle contracted while its action was opposed. It diminished in size and became harder when the muscle contracted actively without opposition.

These facts indicate, as Guinard says, the phenomena which ought to be looked for when there is reason to suppose that hernia of a muscle has taken place. A thorough understanding of them compels the conviction that the cases so far reported, in which it is stated that the tumor became larger and harder when the muscle contracted, were really cases of rupture, and not of hernia of a muscle. As stated above, a hernia under these circumstances must become smaller, and not larger.

There is only one other condition in which the phenomena of hernia of a muscle may be present, and that is when the aponeurosis of a muscle is thinned and weakened at some spot, so that it no longer offers the normal resistance to the muscle itself. A case in which this actually occurred is reported by Guinard.

The rarity of real hernia of a muscle gives peculiar interest to two cases reported by GIESS in the *Berliner klinische Wochenschrift*, No. 11, 1886. In these cases the nature of the lesion was established by cutting down upon it. They also afford a means of determining what is the best treatment for this lesion. In one of Giess's cases, strapping and bandaging did no good, and so he exposed the tumor by an incision, snipped off the protruding portion of the muscle with scissors, and afterwards cauterized a new protrusion with nitrate of silver. The result was unsatisfactory. In the second case Giess cured his patient by cutting down upon the protrusion, removing

it with scissors, freshening the edges of the rupture in the fascia, and suturing them with catgut. After this the external wound was sutured, and the limb—a leg—was confined in a plaster-of-Paris dressing.

We call the attention of our readers to this curious and rare lesion, and to the best way in which to treat it, in the hope that American surgeons may contribute something to confirm or correct the views which we cite.

ABUSE OF PRIVILEGE BY PHYSICIANS.

We have so often had occasion to praise the fidelity with which physicians, as a rule, perform the duties of their office, that it cannot be regarded as an evidence of want of appreciation that we call attention to a matter in which physicians sometimes abuse their privileges and misuse their powers. This matter has recently called forth a cutting paragraph in *Life*, April 12, 1888, in which it is stated that there is a medical precedent for the acquittal of Mr. Jacob Sharp, in the case of a Mr. Thomas Gould, who, when sentenced to imprisonment, acquired quick consumption, and, according to the physicians—"one of whom, by the way, is now attending upon Mr. Sharp"—could be saved only by release from confinement.

The point of this paragraph is obvious. Its application is somewhat weakened by the fact that Mr. Gould was set free and is still living, and that Mr. Sharp was kept in prison and is now dead. But this does not impair the force of the principle involved, or dispose of the insinuation that physicians sometimes permit themselves to be used by criminals as a means of escape from merited punishment. There is good reason to believe that this sometimes actually occurs, and when it does occur, it is a disgrace to the profession. The effect of its rare and occasional occurrence is to lower the medical profession in the eyes of courts and of the community; and to weaken the influence which it ought to have with both. The temptation to yield to the entreaties of those who find themselves in the grasp of the law, from motives of pity or to secure a reward of money or notoriety, may have little influence with those who are called to pronounce upon the physical condition of a prisoner; but the world is apt to judge by appearances, and to conclude that what exercises so much influence upon other men may affect the judgment of physicians also.

For this reason, it may not be amiss to call the attention of our medical brethren to the importance of exercising the utmost caution in interposing the shield of their professional authority between the law and those with whom it is dealing. In this case an error of judgment, or weakness of will, may lead to consequences as serious as would follow absolute rascality; and even the too zealous following of a scientific conviction may bring discredit upon the whole medical profession. In the middle ages the right of sanctuary was so abused that it had to be abolished; and in our age abuse of the protecting power of medical opinion might lead to the utter loss of this power. Such a result would be as unfortunate for the community as it would be for the physician; and we appeal to the members of our profession, for the sake of the really unfortunate, and of those who wish to be just but not vindictive, as well as for their own sake, to see to it that they never abuse their privilege or bring discredit upon one of their most important functions.

THE NEW YORK HERALD AND HYDROPHOBIA.

The occurrence of a few cases of so-called hydrophobia in various parts of the United States of late has furnished the New York *Herald* an opportunity to fan the dying embers of this disorder, and to excite anew in the minds of the community those fears which the members of the medical profession in this country have been working so faithfully to allay. We have investigated a number of the cases reported as hydrophobia by the New York *Herald*, and have found them to be spurious. It is no great damage to the reputation of this newspaper to say that its utterances in regard to hydrophobia are characterized about equally by ignorance and recklessness, and there is little reason to hope

that it will mend its ways for so small a consideration as this. For years it has seemed to be under the impression that it was a noble mission to increase the popular fear of hydrophobia, and has seemed to enjoy the publication of sensational and terrifying details of cases of so-called hydrophobia. This might not be a very dangerous pastime, if it were not for the fact that it is probable that the New York *Herald* is read by a large number of people who are more gifted with curiosity than with wisdom; and we should not call attention to the matter at all, were it not for the fact that we wish to enlist an active opposition on the part of intelligent medical men to an influence which is too serious to be simply ignored. Whenever a daily newspaper begins to publish the details of cases of so-called hydrophobia, there is apt to be a revival of the popular fear of this disorder, and a multiplication of the number of persons suffering with its symptoms. Fortunately for us, the influences which keep up the excitement about hydrophobia in France, and which keep up the number of cases of so-called hydrophobia there, are not active here; and even the New York *Herald* cannot turn back the tide of common sense which every year reduces the mortality from this disorder in the United States. But we think it worth while to characterize its conduct as we believe it deserves to be characterized, and beg our readers to remember the reputation which this particular newspaper has acquired by years of consistent editorial management, when they read its statements of fact or its utterances of opinion on medical subjects.

VACCINATING ESTABLISHMENTS.

The proposition to create an establishment for vaccination in Paris seems to be nearing its accomplishment. The *Gazette Médicale*, March 31, 1888, states that a Commission has been appointed to prepare a plan for such an institution, and that the results of its deliberations will soon be made public. The fact suggests the thought that it might be of advantage to have establishments for the purpose of vaccination in American cities also. At present vaccination is effected in this country in a somewhat desultory fashion, and there is no universally recognized source from which good vaccine virus can be obtained. In the intervals between epidemics of small-pox it is always hard, and sometimes almost impossible, for individual physicians to obtain virus of known good quality; and when an outbreak of small-pox creates suddenly an increased demand for vaccination the resources of physicians are taxed to the utmost. This, we think, would be less likely to be the case if some recognized medical body would found an establishment in which vaccination should be practiced for a moderate fee by persons selected for that special purpose. In such an institution—if it were well supported by the members of the profession—the demand for vaccination would be constant enough to secure a steady supply of good and reliable virus, and medical men would feel safe in recommending their patients to go there for the vaccination of themselves or their children, instead of taking the risks inseparable from the use of such virus as they can secure. In such an institution bovine and human virus could be systematically propagated and a fair test be made of their respective merits. The service of the establishment could be conducted on the same general principles as now govern hospital clinics, and an arrangement might be made for a scale of prices differing at different hours, so that a certain respect should be paid to social distinctions which it might be wise to recognize.

We believe that some such plan as we have now outlined would not be impracticable, and that it might prove very useful.

MURDOCK'S LIQUID FOOD.

This widely advertised article of diet, which had for some time the *quasi* endorsement of certain well-known members of the medical profession in Boston, and which is said to still have the support of the *Annals of Gynecology*, has recently come in for a share of the searching investigations of that admirable paper, the *Boston Journal of Health*. The result has been a description of the character of Murdock's Liquid Food

which is not calculated to increase its popularity with the medical profession. The present state of the discussion includes statements by disinterested medical men that the manufacturer of this food has attempted to deceive the medical profession and the community, and denials and counter charges by Mr. Murdock. As it stands, the latter seems to have decidedly the worst of it; and our readers may as well bear in mind that the claims made for his preparation are discredited by those who probably know most about it and him, and that it is openly placed in the same category with fraudulent articles of commerce.

THE INDEX MEDICUS.

For some years past Mr. George S. Davis, of Detroit, has been publishing, at a pecuniary loss, the *Index Medicus*, which is a monthly periodical, containing a classified index of the titles and authors of papers and books on medical science, appearing from month to month. It is unfortunate that so important a work as this, and one so creditable to the United States, should be dependent upon private enterprise. It ought to be supported entirely by the funds of the Government, especially when this Government is groaning under the burden of a surplus of wealth, which seems to afflict it as much as the poverty of other governments afflicts them.

As it is, we appeal to as many of our readers as have scholarly tastes, to aid in maintaining the enterprise of the publisher of the *Index Medicus*, by forwarding their names and the subscription price—ten dollars a year—to Mr. Davis. Meanwhile we would urge upon them the advisability of trying to influence their representatives in Congress to make this important publication a part of the good work which the National Government is doing in other directions.

—A blind physician of Pensacola, Fla., has a large practice, and is able to find his way, unaided, about the principal streets of the town in a way that would not discredit that popular institution, the oldest inhabitant.

Book Reviews.

[Any book reviewed in these columns may be obtained, upon receipt of price, from the office of the Reporter.]

VALOR DE LA CURA DE LISTER EN LAS HERIDAS CONTUSAS. Por D. Enrique de Areilza y Arregui, Médico Director del Hospital de Triano (Viscaya). Tésis del Doctorado. Small quarto, paper, pp. 32. Bilbao, Typographia Católica de San Francisco de Sales, 1884. (Value of the Method of Lister in Contused Wounds, etc.)

In this interesting inaugural thesis Dr. Areilza argues that the essential character of contused wounds is the diminution or abolition of vitality in the injured parts, and a tendency to the development of putrefaction. For the control of this tendency the application of the principles of Lister's method is almost entirely useless; because the germs which cause such putrefactive changes may come from the interior of the body, and are not necessarily an invasion from without it.

The argument is carefully and elaborately arranged, and is of the most convincing character, being supported by a series of observations and experiments which leave little room for doubt that the opinions of Dr. Areilza are correct.

THIRTY-SEVENTH ANNUAL REPORT OF THE CINCINNATI HOSPITAL FOR THE YEAR ENDING DECEMBER 31, 1887. 8vo, paper, 80 pages. Cincinnati, 1888.

It is not usually desirable to comment upon the reports of hospitals, except when they are as elaborate as those of a few English and German institutions, and contain valuable papers by members of the medical staff. But we may make an exception in the case of the Cincinnati Hospital Report before us, because, in addition to the usual details of house-management it contains unusually well-prepared tables of statistics, and certain appendices of considerable value. One of the best of these is that attached to the medical report, which contains a brief but useful summary of the methods of treating typhoid fever by three of the physicians to the hospital.

It is a great pity that the abundant material of hospitals in every part of the world furnishes so little in the way of broad study of diseases and their treatment, and we wish that some way could be found by which each year should furnish some systematic study of large groups of cases by the medical officers of our American hospitals.

Pamphlet Notices.

[Any Reader of the Reporter who desires a copy of a pamphlet noticed in these columns will doubtless secure it by addressing the author with a request *stating where the notice was seen* and enclosing a postage stamp.]

Igiene Sperimentale. Ancora sui Neutralizzanti del Virus Tubercolare. Nota del Socio Cav. Giuseppe Sormani, Pavia, Italy. From the *Rendiconti del Regio Instituto Lombardo di Scienze*, Ser. II, Vol. XX, Fasc. XIX. 3 pp.

In this little pamphlet Prof. Sormani follows up his recent investigations in regard to the power of a number of chemical agents to destroy the activity of tuberculous virus. The experiments concerned

chiefly the ease and rapidity with which the different agents proved efficient in rendering tuberculous matter inert, and the results announced are interesting; although we do not at present see any very important practical application of them.

Literary Notes and Queries.

[In this column the Reporter will publish short items of literary interest and questions addressed to this Journal or its readers, and answers to them, in regard to any literary matters: books, authors, places and prices of publications, etc.]

—The *Medical Investigator* is a monthly journal, edited and published by S. F. Smith, M.D., at Louisville, Ky. The first number is dated April, 1888, contains 24 octavo pages, and announces that the "subscripion (*sic*) price" is 50 cents a year. It is said to be devoted to medicine and temperance; but the main object seems to be to advocate total abstinence, and the dispensing of their own medicines by physicians. The literary merits of this new venture are not very great, and it does not bear the marks of very vigorous vitality.

Correspondence.

New Use for a State Board of Health.

Editor Med. and Surg. Reporter:

Sir:—An editorial in the last issue of the Reporter, under the heading: "A New Use for a State Board of Health," affords me an opportunity for publicly correcting a misstatement which has been the source of excessive annoyance to the Pennsylvania State Board of Health. The following is the explanation of the very objectionable placard in one of the lines of street passenger railway cars to which you call attention:

The *Annals of Hygiene*, which has been adopted by the Board as its official organ, has undertaken, on its own responsibility, a series of analyses of articles of food, including beverages. These analyses it has from time to time published, with comments on their results. Among the articles thus analyzed were several beers. The proprietor of the beer which showed the best result has taken advantage of the fact that the *Annals* is the official organ of the Board to announce that the Board commends his beer. The subject of beer has never been discussed by the Board. The Board has never authorized an analysis of beers. Perhaps it has been derelict in not doing so; but it conceived that other duties were more important and pressing. The moment that the advertisement referred to appeared in the cars, the secretary addressed an urgent remonstrance to the company against this unauthorized and misleading use of the name of the Board. The only result was the substitution of a second of even a more unwarrantable character than the first. The law is so little to be depended on in redressing a grievance of this kind, that the Board has so far considered it wiser not to appeal to it. It has trusted that the good sense of our citizens would lead them to the same conclusion at which you at once arrived—that "there must be some mistake about this."

Benjamin Lee, M.D.,
Sec. State Board of Health of Pennsylvania.
Philadelphia,
April 24, 1888.

[The mistake to which we referred and which our correspondent regrets, seems to be due to the fact that the State Board of Health of Pennsylvania does not exercise the supervision which it should over a publication which it permits to use its name. So long as the *Annals of Hygiene* is permitted to call itself the "Official Organ" of the State Board of Health, this body will naturally and properly be held responsible for its doings —Ed. Reporter.]

Membership of College of Physicians and County Society of Philadelphia.

Editor Med. and Surg. Reporter:

Sir:—Will you please tell me: 1, What are the qualifications for membership of the County Medical Society and of the College of Physicians? Also, 2, If the fact that a doctor dispenses his own medicine disqualifies him for membership in either?

And oblige, An Ignoramus.
Philadelphia,
April 20, 1888.

[1. *The College of Physicians.*—The Fellows of the College of Physicians of Philadelphia must be physicians, of good character and professional standing, residing within the city of Philadelphia, or within thirty miles thereof in the State of Pennsylvania, over twenty-four years of age, and graduates of at least five years' standing. Candidates for Fellowship must be proposed in writing by three Fellows; their application for Fellowship is referred to the Council of the College, and if approved by the Council, it is voted on by the College, after being read at three successive meetings. An election requires a four-fifths vote of the Fellows present and voting. Entrance fee, $25.00; annual dues, $15.00.

The Philadelphia County Medical Society.—Active members must be graduates of at least one year's standing of a regular medical school, and residents for not less than one year of the County of Philadelphia. Candidates for membership must be proposed in writing by three members, the proposition read at a meeting, referred to the Censors, referred back at the next meeting, and voted on at the meeting following this one. There is an initiation fee of $5.00, and persons elected before the June business meeting must also pay the regular annual dues of $4.00.

2. No! —Ed. Reporter.]

Use of Obstetric Forceps.

EDITOR MED. AND SURG. REPORTER:

Sir:—I would like to call attention to the remarks of Dr. Packard, REPORTER, March 17, 1888, page 337, in regard to the teaching of Dr. A. H. Smith in reference to the obstetric forceps. By referring to Vol. 3, Transactions of the American Gynecological Society, he will see that Dr. Smith *condemns* side to side movements. In Dr. Smith's lectures delivered in the summer of 1884 he strongly condemned lateral or rotatory movements with the forceps. Yours truly,

GEO. W. POTTS, M.D.

New Lancaster, Kan.,
April 18, 1888.

NOTES AND COMMENTS.

The Feeding of Children.

Not until three years old should a child be permitted to take its meals at the table. Parents should understand that even then he has not reached an age when a full diet can safely be allowed.

First of all, he must be taught to eat slowly, and parents certainly ought to set the example. The habit of "bolting" food, so common to many, both children and adults, is an extremely pernicious one, for which there is no excuse.

Even before this period, sound fruits may be allowed children, provided, of course, those easy of digestion are selected, and care is taken to remove the seeds, skins, etc. It will be well to encourage them, when they join the family at the table, to eat a small quantity of fruit for breakfast, and before other foods are served. For this meal, children may be allowed milk, oatmeal, bread and butter, and eggs, either lightly boiled, poached or scrambled. If, instead of eggs, they prefer fresh fish or steak, either one or the other may be given; the meat, of course, must be minced fine. Fried foods are forbidden, and this includes fritters and fried cakes.

At dinner, if the soup is thin, it may be allowed, but that kind of soup so often in the home of the laborer, and which is made from bones, thickened with vegetables, and strongly flavored with onions, is entirely unsuited to a child's digestion, and should never be given it. Roast or boiled meats, such as beef or mutton, may be allowed; the fact that pork and all salted and otherwise cured meats are difficult of digestion should be remembered, and their indulgence forbidden.

Potatoes, baked or boiled, dry and mashed, spinach and peas, string beans, asparagus of good quality, cauliflower, and beets when young, are no burden to a child's digestion, and should be allowed; with green corn it is different, unless that which is very tender is used, and the kernels are carefully crushed or grated. Such vegetables as turnips, cabbage, carrots, parsnips and onions, require strong powers to digest them. The same may be said of celery, unless it is stewed. While the vegetables which have been recommended as a part of children's dietary are usually well borne by them, it must not be assumed that they can safely eat them all at one meal; only two of them should be partaken of each day.

For supper, milk toast, bread and butter, and a glass of milk, with possibly a little stewed fruit, will be quite sufficient for young children. Hot bread, cheese and hashed meat and vegetables, so often the supper of the hearty workman, is altogether too indigestible for young children. In fact, it should be the duty of the mother to learn what foods are easily digestible, and none others should be allowed. Her own powers of digestion, or those of the father, cannot by any means be considered a safe guide in the selection of food for her little one.—*Boston Journal of Health*, March, 1888.

Fatal Effect of Christian Science.

The Philadelphia *Evening Telegraph*, April 21, reports that the town of Medford, Mass., is excited over the death of a Mrs. A. James and her new-born child on April 20. Mrs. Connor, the mother of Mrs. James, practices the cure of diseases by prayer or by the method of a Christian scientist. The husband of the dead woman was away from home on business, and it appears that no midwife or physician, other than Mrs. Connor, was called, until both mother and child were dead. Dr. J. L. Coffin was summoned, and, after inquiring into the facts, insisted upon having an autopsy. The town physician, who assisted in the autopsy, states that it showed that mother and child were perfectly healthy before their decease, and that, with the care she should have been given by a common nurse, both would have been alive. It is probable that Medical Examiner Durell will institute legal proceedings against Mrs. Connor.

Contrast between Strychnine and Alcohol.

Dr. Jaroshevsky has instituted experiments upon dogs with regard to the contrast between strychnine and alcohol, and has

come to the following conclusions: 1. Strychnine neutralizes the narcotic and toxic actions of alcohol. 2. With the addition of strychnine, large doses of alcohol may be taken for a pretty long time without the appearance of those changes in the organs which occur after the use of alcohol. 3. Strychnine should be given in all forms of alcoholism. 4. Strychnine may be considered as a powerful prophylactic agent against alcoholism.—*Deutsche med. Wochenschrift*, March 13, 1888.

Poisoning from a Belladonna Plaster.

Dr. J. E. Horn, in a letter to the *Cincinnati Lancet-Clinic*, March 31, 1888, states that for a painful arm he applied a belladonna plaster to relieve the soreness; the plaster was four by eight inches in size. It was on about thirty hours, and because of the burning it produced the patient removed it, and a vesicated spot the size of the plaster was visible. Two days later he was called in, and on looking at the arm was frightened to find the denuded surface of a deep, angry red, and a scarlet hue extending from its edges in every direction. The arm was swollen all the skin would admit of from shoulder to elbow, even extending to the fingers and hand, but not so great below the elbow. The patient complained of dryness of the throat, and had double vision. The inflammation remained about in the same condition for three days, and then began to gradually subside. The patient told him that she was served nearly the same way years ago, when another physician had applied a "plaster." She also said that turpentine or coal oil would blister her in a few minutes if applied to the skin.

Care of the Pauper Insane.

It is reported from Albany, N. Y., under date of April 13, that the Assembly has passed an Act, by a vote of 77 to 7, authorizing the Overseer of the Poor of Ulster County to remove to that county for its keeping any indigent chronic insane it may have in any State insane asylum.

The act was strongly opposed by several members of the Legislature, as a backward step in the method of providing for the indigent insane.

Polydactylitis.

In Oerebro, Sweden, a shoemaker and his son have on both their hands two thumbs each, which are fit for work. This surplus of fingers is present also in a brother of the shoemaker and in four of his children, but in these five persons the supernumerary finger is not capable of work. The mother of both the brothers has six toes. No such peculiarity has been reported concerning the grandmother on the mother's side; but the great grandmother is known with certainty to have been supplied with six fingers on each hand. This deformity has therefore been transmitted through five generations.—*Allgemeine med. Central-Zeitung*, Feb. 11, 1888.

Acid Bichloride Solution.

Prof. Krönlein, of Zürich, communicates the following formula for an acid solution of corrosive sublimate with salt, to the *Correspondenz-Blatt für Schw. Aerzte*, No. 4, 1888:

Hydrarg. bichlor. cor.	16 oz.
Sodii chloridi, Acid. acetici dil (20.4 %), of each	8 oz.
Aquæ	32 oz.

M. Sig.—10 % corrosive sublimate solution.

This concentrated solution is kept on hand in the shops and clinics, marked with the word poison, in order to quickly prepare the customary $\frac{1}{20}$ to $\frac{1}{10}$ per cent. solutions for surgical purposes. According to Meyer, of Göttingen, it remains clear both in the dark and light, and forms no basic precipitate with strong lime water even after being kept for months.

Puerperal Eclampsia.

Dr. William Goodell in a letter to the *Medical Standard*, April, 1888, says: "In the majority of cases of puerperal eclampsia, I limit my treatment to chloral hydrate thrown up the bowel. This is repeated whenever twitchings or other premonitory symptoms of recurring convulsions manifest themselves. In plethoric cases I bleed first and then give chloral hydrate per rectum. Whenever convulsions are threatened I either bleed or else give chloral hydrate per os in smaller doses until headache is relieved or until the twitching, double vision or blindness are removed. If labor has begun, I give chloroform, not ether, and deliver rapidly. If labor has not begun, I watch and await events, interfering only when compelled."

Prescription for Headache.

Dujardin-Beaumetz recommends the following:

℞ Caffeine	gr. iv
Salicylate of sodium	gr. iv
Hydrochlorate of cocaine	gr. iss
Water	f℥ij
Syrup	f℥vss

M. Take the whole at one dose at the beginning of the attack.

Salol as an Antiseptic.

Just as antipyrin after its original applications was found to have numerous others equally effective, so it is now with salol, which seems likely therefore to presently command a more extensive patronage. One of these seems to be really important. The antiseptic properties of the compound have always been recognized, but salol has never been applied externally. Now, however, continuing the parallel with antipyrin—the most important property of which was discovered in a country other than that in which it was first used—salol has been proved to be a valuable antiseptic in France, Italy, and Switzerland. It is specially recommended as a substitute for iodoform, in all cases in which the latter has been previously used, and considering its freedom from objectionable odor, it is not astonishing that its application in this direction should find favor. Moreover, it is not toxic, which is more or less the case with iodoform. Another advantage is that it is about twenty per cent. cheaper than iodoform.—*Chemist and Druggist*, March 24, 1888.

Lafayette Mixture.

The Lafayette mixture as recommended by Bumstead (1870) is as follows:

℞ Copaibæ.....f℥ j
Liq. potassæ.....f℥ ij
Ext. glycyrrhizæ.....℥ ss
Spir. æth. nitrosi.....f℥ j
Syrupi acaciæ.....f℥ vj
Olei gaultheriæ.....gtt. xvj

Mix the copaiba and the liquor potassæ, and the extract of licorice and sweet spirit of nitre first separately, and then add the other ingredients.

Dose.—A tablespoonful after each meal.

Dr. Keyes's modification of this formula is as follows:

℞ Potassæ citratis.....℥ ij–vj
Bals. copaibæ.....f℥ iij–vj
Ext. hyoscyami fl.....f℥ ss–ij
Syr. acaciæ.....f℥ iss
Aquæ menth. pip....q.s. ad...f℥ iij

M. Sig.—Shake. Teaspoonful in water.

Formula for Tobacco Amblyopia.

A. St. Clair Buxton says (*Lancet*, Feb. 25, 1888), that the following formulæ have proved useful in this affection:

Liq. hydrarg. perchlor. (B. P.)..f℥ ss
Potassii iodidi.....gr. xij
Aquæ destil. ad .....f℥ j

Sig.—Take three times a day.

Ext. nucis vom.....gr. ss
Ext. hyoscyam.....gr. j

Ft. pil. No. j. Take with each dose of the mixture.

Amylene Hydrate.

The testimony as to the good effect of amylene hydrate as a hypnotic continues to grow. Georg Buschan has a good word for it in the *Beliner klin. Wochenschrift*, March 19, 1888. He thinks that amylene hydrate, although not a hypnotic of the first rank, is a substitute for chloral and paraldehyde, possessing the preference over the former in not being in so great a degree a cardiac depressant, and over the latter on account of better action with smaller doses, and also because it lacks the unpleasant odor exhaled from patients taking paraldehyde. He thinks it should be used in general medical practice, and reports success from its hypodermic use.

Antifebrin.

Dr. E. Houston, of Stanberry, Mo., writes to the *Weekly Medical Review*, April 7, 1888, that he has obtained excellent results from the use of antifebrin in inflammatory rheumatism, neuralgias, and as a hypnotic in insomnia due to reflex nervous phenomena in women. He has also given it in cases in which the extremities were cold and bathed in clammy sweat, temperature below normal, and heart embarrassed. These symptoms, he says, disappeared in an hour. He regards it as a heart tonic.

Successful Case of Cæsarean Section.

Dr. Howard A. Kelly, of Philadelphia, did the improved Cæsarean operation, April 17, 1888. The patient was a dwarf, fifty-two inches in height. The indication for the operation was absolute, as the patient had a generally contracted pelvis with a true conjugate estimated at 2¼ inches. The woman had been in labor nine days, and the membranes ruptured four days, before Dr. Kelly was called. The whole operation occupied thirty-seven minutes, the delivery of the child, five minutes. The patient is doing well, eating heartily, with a pulse of seventy. The child died of jaundice at the end of a week. Should this woman recover, and there is every reason to believe she will, it will be the first recovery under Cæsarean section in Philadelphia in half a century.

The Sense of Taste.

Science, March 23, 1888, contains an interesting paper by E. H. S. Bailey, and E. L. Nichols, on the delicacy of the sense of taste. These investigators found, by experimentation, that men detected one part of quinine in 392,000 parts of solvent, women one part in 456,000; men detected one part of acid in 2,080, women one part in 3,280;

men detected one part of salt in 2,240, women one part in 1,980; men detected one part of sugar in 199 parts, women one part in 204; men detected one part of soda in 98 parts, women one part in 126.

From these results the following conclusions may be drawn:

1. The sense of taste is much more delicate for bitter substances than for any others. It is possible to detect quinine in a solution which is only $\frac{1}{200}$ the strength of a sugar solution—and quinine is only $\frac{1}{10}$ as bitter as strychnine.

2. The order of delicacy is, bitter, acid, salt, sugar, and alkali.

3. The sense of taste appears to be more delicate in women than in men. This is true in the case of all the substances except salt. A similar difference was found in favor of female observers in an earlier and independent set of experiments, which agreed in every essential particular with the results of the present test.

Marked differences in the delicacy of the sense of taste of different individuals were met with in the course of these experiments. There were persons who could place in the proper class, solutions containing one part of quinine in 500,000, and other substances in corresponding high dilution, while some failed to detect solutions of more than three times the above strength. Among the men examined were many who have been accustomed to handling and recognizing drugs and medicines, and yet even these were frequently surpassed by female observers who had no such training.

In a few cases, the ability to detect a dilute sweet was accompanied by a lack of ability to detect dilute bitters. This peculiarity was, however, far from being a general one. Among the observers subjected to experiment, the frequent use or disuse of quinine seemed to have had no special influence as effecting its detection.

As to the degree of delicacy of the human sense of taste for the substances in question, there is reason to believe that they are but slightly influenced by individual idiosyncrasies, and may be regarded as fairly representative.

Pennsylvania State Medical Society.

The Pennsylvania and the Philadelphia and Reading railroads and their branches will sell excursion tickets for the session of the Medical Society of the State of Pennsylvania in Philadelphia in June next. Application for an order, naming which road, may be made to Dr. Wm. B. Atkinson, 1400 Pine Street, Philadelphia. Tickets will be sold for one-third less than the usual rate.

NEWS.

—Dr. George M. Gould has removed to 119 South Seventeenth street, Philadelphia.

—Dr. Clara Marshall has removed to 131 South Eighteenth street, Philadelphia.

—According to a provision in the Budget presented by the Chancellor of the Exchequer to Parliament, English physicians are threatened with a tax of five dollars on their horses.

—The *British Medical Journal*, April 21, 1888, announces the death of Dr. De Chaumont, who succeeded the late Professor Parkes in the chair of Military Hygiene, at the Royal Army School, England.

—Since the first of January there have been 78 cases of small-pox reported in Philadelphia. Of this number 42 were sent to the Municipal Hospital, and eleven died. The number of cases is diminishing.

—Governor Beaver has appointed a commission, under the act of June 14, 1887, to select a site and erect thereon a hospital, at or near Hazleton, Penna., for injured persons in the middle coal fields. An appropriation of $60,000 has been made for the purpose.

—Dr. R. B. Root reports to the *Boston Med. and Surg. Journal*, April 19, 1888, that he recently attended in confinement a young woman, 15 years old, whose great-great-great-grandmother is still living at the great age of 95 years, so that six generations of the family are now alive.

—The Marshall Hall prize has been awarded to Walter Holbrook Gaskell, F.R.S., Lecturer in Advanced Physiology in the University of Cambridge. This prize is given every five years for the best original work done during that period in physiological or pathological research.

—The next meeting of the American Gynecological Society will be held in Washington, September 18, 19 and 20, in order to give the members of the society an opportunity to attend the sessions of the Congress of American Physicians and Surgeons, which is to be held in Washington at that time.

—The *Northwestern Lancet*, April 15, 1888, says that in the vomiting of early pregnancy, lying with the shoulders low and the hips elevated will give quick relief. A linen compress saturated with French brandy, strapped tightly over the gastric region with adhesive plaster, acts mechanically in holding the muscles quiet, and will sometimes do wonders in these cases.

HUMOR.

INDIGNANT PHYSICIAN: "Man, what have you done? You sent my patient the wrong prescription, and it killed him."

Druggist (a calm man, accustomed to abuse): "Vhell, vhat vas der madder mit you? Last veek I send your odder patient der righd berscription, and dot killed him. How can somebody blease sooch a man?"—*Brooklyn Eagle.*

STRANGER (in drug store): "You seem to carry an extensive line of goods."

Proprietor (affably): "Yes, sir."

"I've been told that you are a reliable man to deal with."

"You will find everything just as represented, sir. What can I have the pleasure of doing for you?"

"I guess I'll take a look at the directory."—*Judge.*

IN AN ITALIAN JOURNAL, *Il Giornale delle due Sicilie*, there was, not long ago, a translation of a paragraph in an English newspaper, giving an account of a man having beaten his wife with a poker. The word "poker" was not intelligible to the editor. He, however, had the candor to admit his ignorance, which he did in the following language: "Non sappiamo, per certo, se questo 'pokero' Inglese sia uno strumento domestico o bensi chirurgico"—"We do not know with certainty whether the English poker be a domestic or surgical instrument."—*N. Y. Evening Post.*

JAMES PAYN, THE NOVELIST, is editor of the *Cornhill Magazine*, London. Next door to his office a medical journal has its sanctum. One day Mr. Payn's door was cautiously opened and a pale-faced, long-haired individual entered. "I have brought a little thing about sarcoma and carcinoma," said the visitor. "Very sorry, sir," said Payn, politely, "but we have all the poetry we want." "This isn't poetry!" exclaimed the visitor. "It is an essay on two varieties of tumor." "Oh, I beg your pardon," said Payn, "I thought they were a pair of Italian lovers." The long-haired man was a well-known professor who had entered the wrong office.

OBITUARIES.

ANDREW B. VAN HORNE, M. D.

Dr. Andrew B. Van Horne died at Orange, N. J., March 31, of pulmonary phthisis. He was graduated from the College of Physicians and Surgeons, New York, in 1880, and not long afterwards was obliged to go to Colorado Springs for the sake of his health, and returned from there only last summer.

THOMAS D. WORDEN, M. D.

Dr. Thomas D. Worden, of Wilkesbarre, Pa., died in Fort Plain, N. Y., April 19, 1888, at the age of 34 years. He was a graduate of Albany, N. Y., Medical College. The last year of his life was spent in Colorado Springs, Colorado, where he went thinking that the climate would be beneficial, suffering as he did from lung trouble. His disease, however, resulted in his death, two weeks after returning to the East.

EDWARD GREELY LORING, M. D.

Dr. Loring died suddenly in New York, April 23, in the fiftieth year of his age. On the day of his death he attended to his practice as usual. It is understood that his sudden death was owing to heart disease, though no such affection was known to his friends, and probably not to himself.

Dr. Loring was graduated from the Medical Department of Harvard University, in 1864. He soon came to New York, and for a time was associated in practice with the late Dr. Agnew. At the time of his death, and for many years before, Dr. Loring was one of the surgeons of the New York Eye and Ear Infirmary. He was widely known and generally recognized as an authority upon ophthalmoscopy. His "Text-book of Ophthalmoscopy," the first volume of which was published in 1886, took rank at once as the standard American work on that subject. His death is the more to be deplored as it follows so closely upon that of Dr. C. R. Agnew, and so makes two notable vacancies in the ranks of New York ophthalmologists.

Official List of Changes of Stations and Duties of Medical Officers of the U. S. Marine Hospital Service, for the two weeks ended April 21, 1888:

W. H. H. Hutton, Surgeon, to proceed to Biloxi, Miss., on special duty, April 21, 1888.

W. H. Long, Surgeon, granted leave of absence for fourteen days, April 21, 1888.

H. W. Sawtelle, Surgeon, granted leave of absence for seven days, April 21, 1888.

F. M. Urquhart, Passed Assistant Surgeon, granted leave of absence for seven days, April 10, 1888; to assume temporary charge of Cape Charles Quarantine Station, April 17, 1888.

J. H. White, Passed Assistant Surgeon, relieved from quarantine duties at Sapelo Station, April 21, 1888.

L. L. Williams, Passed Assistant Surgeon, relieved from duty at Marine Hospital, Boston, Mass.; to assume charge of Cape Charles Quarantine Station, April 17, 1888.

W. D. Bratton, Passed Assistant Surgeon, relieved from duty at Marine Hospital, San Francisco, Cal.; detailed as medical officer, Revenue Steamer "Bear," during Summer cruise, April 19, 1888.

Changes in the Medical Corps of the U. S. Navy for the week ending April 28, 1888.

Medical Inspector A. S. Oberly granted six months' leave, with permission to visit Europe.

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Communications.

THE APPENDIX VERMIFORMIS; ITS FUNCTIONS, AND PATHOLOGICAL CHANGES AND THEIR TREATMENT.[1]

BY J. M'FADDEN GASTON, M. D.,

PROFESSOR OF SURGERY, SOUTHERN MEDICAL COLLEGE, ATLANTA, GA.

Preliminary to a consideration of the functions pertaining to any organ, it is requisite to understand its structure, or in other words the physiology of a part depends upon its anatomy. The presence of the appendix vermiformis in man and in some of the higher orders of apes, while it is absent in quadrupeds and other inferior animals, may perhaps lead the followers of Darwin to the conclusion that the missing link is to be sought in this development; but I have no inclination to enter into the abstruse questions of evolution, and only regret that we are precluded from receiving any information from a study of comparative anatomy in respect to this unique appendage. If the dog and cat were supplied with this structure, the facility for making experiments upon them might enhance very much our knowledge of its normal and abnormal conditions, whether idiopathic or traumatic; but the door is shut to all such investigation, and the human subject does not fully avail for satisfactory data in regard to its structure and its office. In its general outline the appendix is subject to great variations of size and position, being found in different subjects from three to six inches in length, and lying diversely in its relation to the cæcum. Its diameter admits of considerable changes owing to the variable contents of the canal, whether gaseous, mucous or serous. This tube is of the same size from its attachment to the lower wall of the cæcum to its termination in a blind pouch at its free extremity; and when empty or occupied only with mucus this measurement is ordinarily about one-fourth of an inch. There is usually a mesenteric attachment to the wall of the cæcum, and this duplicature of the peritoneum invests its entire length, while a muscular layer is found between this and the mucous membrane which lines it. The opening into the cæcal cavity has a valvular arrangement of the mucous membrane which is capable of closing the orifice, and doubtless ordinarily prevents the entrance of foreign bodies into this blind pouch. It becomes dilated, however, under certain circumstances so as to admit of the passage of small solid masses through this orifice, and these become arrested in the tube and prove a source of disturbance. In view of this fact, this valve has been regarded by some writers as a trap, which is very prone to cause obstruction of the canal of the appendix by foreign bodies, as when the latter are once introduced there is perhaps a kind of constriction of the orifice of the appendix which interferes with their escape. That there exist in the middle coat of the appendix longitudinal and circular muscular fibres, which by their alternate contraction and relaxation provide for a serous or mucous exudation, and after certain modifications in it promote its expulsion, is very evident from a study of the histological elements of its organization. Whether or not any considerable proportion of fæcal matter enters the cavity of the appendix has not been determined, but it seems most probable that the quantity must be small in view of the relative size of this diminutive tubular sac and the capacious cæcal

[1] Read in the Surgical Section of the American Medical Association at the meeting in Cincinnati, May 11, 1888.

pouch which receives the contents of the ileum through the ileo-cæcal valve. The capacity for distension being limited in extent, precludes the view that the cavity of the appendix may serve as a diverticulum in cases of undue accumulation of fæcal matter in the colon. An opportunity has been recently afforded me of noting that obstruction of the descending colon from an organic stricture, inducing such distension of its walls by the retained contents as to result in perforation and death, did not materially affect the size of the appendix vermiformis. It cannot, therefore, be regarded as a safety-valve for the cæcum, but is rather to be looked upon as a loop-hole for the entrance of matters prejudicial to it and the adjacent structures; and may be appropriately regarded as a danger signal to warn the organism of approaching trouble.

The location of the orifice of the vermiform appendix at the most dependent part of the caput coli, while the entrance of the ileum through the ileo-cæcal valve is above and at the inner side, affording a direct passage to the contents of the alimentary canal into the cæcum as a receptacle, would seem to favor the conclusion that some change is there brought about by the contact of fæcal matter with the discharges from the appendix.

Its mucous lining, according to Gray, is furnished with a large number of solitary glands, and Satterthwaite states in his "Manual of Histology" that "in the vermiform appendix we find the collection of solitary lymph follicles so closely placed that the space left between adjoining glands does not equal in diameter that of these structures themselves."

On the other hand, we learn from Quain that "in man the chief function of the cæcum is absorption, as is shown by the great number of lymphatics in its walls;" while Landois tells us that "the contents assume the characters of fæces and become formed in the lower part of the great intestine." The high authority of Littré warrants the assertion that "it is in the cæcum that the residue of the alimentary substances assumes all the characteristics of fæcal matter;" and in the absence of other explanation of the peculiar odor imparted to the contents of the colon from this point forward, it is fair to infer that this modification comes from the influence of the appendix vermiformis, either by some chemical or vital process.

I have not such data to hand in support of this view as will stand the test of scientific criticism. Notwithstanding the fact that I am without material for vivisection, in the absence of wombats and apes, while the opportunities for elucidation from observations upon the human body are few, yet upon the principle of exclusion it is expected that this theory of the function of the appendix may be entitled to consideration. As its province in the animal economy has not heretofore been pointed out by physiologists, I would appeal to them to recognize this hypothesis, on the same basis that the owner of a certain historic dog in the backwoods of North Carolina claimed that he was a good "'possum dog,"—that he had tried him thoroughly for every other species of game without discovering any hunting qualities, and hence he concluded that he ought to be good to catch the opossum. Reasoning upon the general principle that all the organs of the human body are fitted for the discharge of a useful end in the animal organism, we are not warranted in concluding that the appendix vermiformis is an exception to this rule of the fitness of things, and it behooves us to investigate seriously its function. We should satisfy ourselves as to its relations to the digestive and excrementitious processes, with its position as a sentinel at the gateway, without participating, so far as is known, in the work of alimentation or defecation.

The antiseptic property of sulphurous gases is well known, and the presence of sulphuretted hydrogen in the colon cannot be accounted for by any process of decomposition developed in its contents, as the cases of arrest of fæcal matter, with or without impaction, are not attended with such results as would ensue from such a process. We are therefore warranted in attributing the absence of any signs of degeneration to the presence of an antiseptic element, which is developed in the vermiform appendix and intermingled with the fæcal mass in the cæcum, which serves as a reservoir where this process may be undergone as the residue of the alimentary substances is poured out of the small intestines. The effectual security against regurgitation afforded by the construction of the ileo-cæcal valve, as well as the barrier formed by the valvular opening of the appendix, which prevents the entrance of fæcal matter into its cavity, while gaseous emanations or its natural secretion of mucus may pass out into the caput coli—these facts favor the view that an important office belongs to the appendix vermiformis in preserving the contents from decomposition during their progress through the colon, an office beyond that claimed for the admixture of the bile elements with the excrement. It

is evident that ordinarily the fæces do not enter the canal of the appendix, owing to the nature of the duplicature at its orifice, and when by failure of this impediment, solid matters, fæcal or otherwise, do enter its cavity, there is no capacity in its walls for their expulsion. It therefore follows that in case of such accidents an inflammatory process is developed in the appendix. The number of cases in which the appendix has been removed by operative procedures, or has been obliterated by disease, are thus far comparatively few, and the observations upon the effects of such loss have not been reported in such a way as to throw any light upon the function of this development which characterizes a higher order of animal creation. The vague conception that the appendix is rudimentary in nature seems to have taken possession of physiologists without any show of reason or any foundation in fact, so far as the study of comparative anatomy can aid in directing us to a satisfactory conclusion. If it can be made to appear that the native population of our primeval forests, which subsisted largely upon herbs and roots, with an admixture of animal food, presented any marked increase of development in this respect, it might go towards sustaining this claim. But this hypothesis is far-fetched, and I am not aware of any such facts to corroborate it, nor are there any data available from the history of the human race since the creation of mankind, which tend towards a confirmation of this view; and the attempt to bolster up a theory without facts is only an acknowledgment of utter ignorance.

The increased number of disorders of the appendix vermiformis which have been recognized in these latter years might lead to an inference that it is destined to entire obliteration in the course of time, were it not evident that many affections of the appendix were formerly ignored from the lack of proper observation in diagnosticating the troubles of this region. Should it appear in the future that the appendix vermiformis may be removed with impunity, then it will only prove what has been demonstrated in the case of other important members of the body, namely, that they are not essential to the human organism. But no one would undertake to set aside the important office of the ovaries in the *rôle* of creation, because, forsooth, they have been removed without detriment to the subsequent health and comfort of the individual. It strikes me forcibly that the practice of oöphorectomy resorted to so frequently of late for slight causes, and in some instances without indications of disease in the organ, may at no distant day be held as an excuse for cutting down upon the vermiform appendix on the slightest provocation, for the purpose of ligating and excising it, and thus ridding the individual of further trouble from its disorders. How far this might be justified from a consideration of the great risk to life attending inflammation and perforation of its walls, depends, in the absence of trustworthy data for an early diagnosis, upon the importance which may be attached to the function of this peculiar structure, after further observation of the effects of its removal; and surgeons must await the result with interest.

Whether inflammation is developed in this structure independent of mechanical irritation from the entrance of foreign bodies or the formation of fæcal concretions, has not been clearly demonstrated. Clinical observation in cases which yield to treatment leave doubts as to the real seat of the disease referred to this region, and so far as noted in *post-mortem* examination the lesions have for the most part been referred to the presence of a mechanical irritant. While some have asserted that inflammation is set up in the vermiform appendage as a result of derangement of the digestive apparatus, and others have supposed that the entrance of germs into its cavity has developed morbid processes in its structure, the facts go to prove that such causes of disease are rare in comparison with the troubles growing out of local irritation of a mechanical origin. It is remarkable that the presence of such foreign bodies rarely produces any serious inconvenience until perforation of the wall of the appendix ensues, and even then the localization of the pain and inflammation is not well defined, either by the sensations of the patient or by objective symptoms recognized in a physical examination by the practitioner. There is an absence of preliminary indications pointing to the nature of the inflammatory process at the incipiency of the disorders of the appendix vermiformis, which presents to the surgeon a problem difficult of solution.

At this early stage there may, however, exist a certain degree of sensitiveness upon pressure immediately over the site of the appendix, and this tenderness, revealed by cautious palpation, may serve for the recognition of an incipient inflammation in the appendix, when as yet there is no perceptible thickening or induration of the tissues. It is clear that the effects of the causative influence, of

whatever character it may be, must, up to a certain point, be of gradual operation in the development of inflammation. During this stage it is of the greatest importance to be able to recognize its progress, and not only should the external examination be carefully made, but the digital exploration by the rectum should also be directed to the discovery of the seat of the inflammation in the appendix.

There are in most instances some concomitants of the local trouble manifested in the derangement of the alimentery canal, perhaps of a reflex order, prior to the extension of the inflammatory process to the adjoining structures. In the early history of appendicitis, it has been noted that there may occur either a disposition to frequent evacuations or a state of intestinal torpidity, in which it is difficult to arouse the peristaltic action of the bowels either by purgative medicines or enemata. During this period the constitutional disturbance is not very marked, and yet there exists usually a febrile state, with slight rise of temperature, so that nice discrimination will detect a departure from the normal condition of the general system. While the presence of fæcal concretions or other foreign bodies in the canal of the appendix may be tolerated for a greater or less period without any manifestion of trouble in the ordinary performance of the functions of the intestines, there are good and sufficient grounds for the conclusion that intestinal derangement from other sources may become an exciting cause of developing the inflammatory process from the local irritant. The history of cases in which death has occurred from other diseases, present quite a number of instances in which there were unmistakable indications of disease of the appendix which had terminated by resolution. But it is generally found that inflammation set up in the wall of the canal from a mechanical irritant, leads to perforation and extravasation of the contents, accompanied by characteristic shock immediately, and followed by diffused inflammation. This is the dividing line between two distinct phases of symptoms, and whatever may have obscured the case previously, it is for the most part well defined after this grave result. There may be only a circumscribed involvement of the surrounding structures, exciting adhesive inflammation in the serous tissues which shut in the exudation from the cavity of the appendix, thus forming a local abscess. But usually the septic matter permeates in different directions and sets up general peritonitis, with a train of constitutional troubles, attended with marked cerebral disturbance and vital depression.

An observation of a peculiar pain in the penis from the perforation of the vermiform appendage has been reported by Tiffany, and the same marked feature occurred in my two cases of perforation which were verified by *post-mortem* examinations. In the elaborate paper of Fitz on Perforating Inflammation of the Vermiform Appendix, some stress is laid upon the disturbance of the urinary and genital organs. During the first three days following the onset of the pain connected with perforation, micturition is occasionally disturbed. Perhaps unusually frequent on the first day, it is likely to be difficult on or after the third day. In certain instances the use of the catheter is required. The right testicle may be retracted and swollen, in which case the course of the pain is apt to be toward this gland. We can understand how the escape of irritating matter from the appendix should cause trouble by transmitting inflammation to the contents of the abdomen, including the pelvic viscera, but it is not apparent that such disturbance of the urinary and genital organs results from general peritonitis induced by other causes, and the pain in the penis cannot be attributed to the peritonitis. If it should be found that this painful development in the penis is present in the early period of appendicular inflammation, and is not a result of perforation, it would aid very much in making the diagnosis at this stage.

We have the authority of a standard work on pathological anatomy and histology for stating that the most frequent form of inflammation of the appendix is a suppurative one. The appendix is swollen and congested; its walls are infiltrated with pus; at some points there may be necrosis and sloughing of portions of its walls. Within the cavity of the appendix we find fæcal concretions or foreign bodies, or nothing (but mucus). Such an inflammation may terminate in resolution, but more frequently it sets up an inflammation of the surrounding tissues. This inflammation may be either a local or general peritonitis or a suppurative inflammation of the parts about the appendix. Less frequently there is a chronic inflammation of the mucous membrane of the appendix, followed by constriction of its upper portion, while the lower part is dilated into a cyst filled with mucus and serum. (Delafield and Prudden.)

Another elaborate treatise on Pathological Anatomy and Pathogenesis, states that typhlitis and perityphlitis imply inflammation of the vermiform appendage and parts around it.

The vermiform appendix is peculiarly adapted to catch and retain substances pass-

ing through the cæcum. Matters which have been swallowed—such as grape-seeds, apple-pips, cherry-stones, and the like—and fæces, may accumulate in the appendage and set up inflammation. Sometimes these become crusted over with phosphates and carbonates, and so form fæcal concretions or calculi. The inflammation thus set up may extend to all the coats of the appendage, and then attack the contiguous structures, and in this way necrosis and gangrene, with perforation, may be caused. The issue differs in different cases. It is comparatively favorable if the inflammation continues to be circumscribed, while the exudation is moderate in amount; protective adhesions and false membranes may thus be formed about the affected spot. It is very unfavorable when perforation takes place before adequate adhesions are formed; fatal peritonitis is nearly always induced. When perforation takes place into a part of the peritoneum shut off by adhesions, a burrowing fæcal abscess is produced, which may burst internally or externally. Sometimes the appendage is entirely obliterated by adhesive inflammation; but if the inner or intestinal end becomes closed while the remainder continues to be patent, the natural mucous secretion may collect in the latter and distend it into a cyst. It is likewise specially noted that tuberculous and typhoid ulceration, localized in the vermiform appendage, may give rise to dangerous lesions. (Ziegler).

It is not out of place to repeat what has been stated by me in another recent publication, that I cannot acquiesce in that view of pathologists which attributes the degeneration of the cæcum and appendix to a low state of vitality in their tissues, but on the contrary I hold that they are highly vitalized, and that it is from being overtaxed in the performance of functions essential to the discharge of the excrement, that they are so subject to disease. I agree with Agnew in considering inflammation as hypernutrition, and consider that it is an effort of nature to restore the equilibrium of the circulation which has been interrupted by a local morbific impression from the causative agent. This inflammatory process is an attempt at recuperation of the injured part, and within certain limits it is salutary; but when it transcends the powers and capacities of the organism, I infer that from the undue excitation and over-action of this extraordinary impulse there is a breaking down of the forces of the organization, which leads to disintegration and death of the structures involved. By the development of inflammation in the tissues of the cæcal region, nature is resenting an insult to the components of this organ, and when it triumphs over the difficulties encountered, resolution ensues; but if it fails, there is ulceration and perforation, leading to abscess and peritonitis. To illustrate the important vital connection of the ileo-cæcal structure with the general organism, I may refer to the fatal results of the resection of this division of the intestinal canal in dogs, reported in my paper in *Gaillard's Journal* on Obscure Impediments of the Intestinal Canal, while resection of a portion of the ileum was followed by complete restoration of the intestines. These deaths occurred in less than twenty-four hours, indicating that they were the effect of shock, which can be explained only upon the basis of a most intimate association of this structure with the organic nervous system.

Being therefore convinced of the traumatic reaction on the part of the cæcal division of the intestines as a consequence of injuries or morbific impressions, I would urge a prompt recourse to curative measures.

In regard to the procedure for the treatment of the diseased appendix, all writers are pretty well agreed upon using anodynes and keeping the patient at rest in the early stage with soothing fomentations over the iliac region; but some have resorted to a mild purgation or to an enema to secure evacuations, when the bowels are bound at the outset, and afterwards use opiates in full doses continuously. It may be put down as a dogma in the management of incipient cases of appendicitis that perturbation of every kind is hurtful, and that masterly inactivity should be observed with a view to promote resolution of the inflammatory process if this be possible, thus averting suppuration and perforation. With the uncertainty which hangs over the diagnosis in the early stage of appendicular disorder, the expectant treatment is generally recognized as the most prudent course, but there is a growing tendency among surgeons to cut the Gordian knot by a decisive step, and use an exploratory operation by incision for determining the exact seat and character of the disturbance. Aggressive practitioners, such as Bull and Weir, with others, have inculcated surgical interference at the earliest practicable period, and with the lights before us in cases of this kind the surgeon is warranted, so soon as he has good and sufficient reason to believe that there exists progressive inflammation of the appendix, in verifying this diagnosis by cutting down upon it. This course is indicated when the

symptoms of a local and constitutional or general nature are such as to raise a presumption in favor of appendicular inflammation, in advance of those phenomena which usually accompany perforation. In other words, an exploratory operation is advisable with a view of learning the exact condition of the parts involved. In the event of finding no evidence of inflammatory action in the tissues of the appendix or cæcum, and when no indurated mass can be discovered by palpation in either, after careful exploration the incision may be closed without any probability of serious consequences.

If, however, on the contrary, appendicitis is verified, with or without the recognition of a solid body within its canal, it would be proper to ligate or suture the cæcal attachment, and excise the appendix vermiformis as a security against further inflammatory developments in its structure. Thus, all liability to the graver results of perforation would be most effectually obviated, and thus surgery of a destructive order would eventually prove to be conservative in preventing other grave consequences. The diagnosis of appendicular disorders cannot be guaranteed without an exploratory operation, as the statements of those most familiar with this class of cases show most conclusively, and it cannot augment materially the risk to life, while it insures a radical cure when disease exists.

An incision may be made outside of the right rectus muscle. The extension of the opening upward along the linea semilunaris would be indicated in case a suppurating track should be discovered, as was noted in my case of perforation of the appendix.[1] This was shut off from the general peritoneal cavity by adhesions, so that it left the iliac fossa and reached the diaphragm on the right side, burrowing behind the liver in the form of a cloaca, which could not have been explored properly by an incision in the linea alba, owing to the adhesions existing there between the intestines and the abdominal wall.

In a recent laparotomy for volvulus of the ileum, near its cæcal connection, such difficulty was encountered in the exploration of the seat of disease through an incision in the median line from the umbilicus to the pubes, that it was found necessary, in order to effect my object, to extend my incision upwards to a point midway between the umbilicus and ensiform cartilage. The walls of the intestine involved in the twist were agglutinated and the canal entirely occluded, and there was also disintegration of the ileum on each side of the obstruction. The cæcal segment was ligated, and the other was cut beyond the gangrenous line and stitched into the median incision, as is done in the process for artificial anus upon closing the abdomen.

If the site of the trouble could have been known in advance, as is presumed to be the case in appendicitis, it would certainly have required a shorter incision in the linea semilunaris than was found necessary in the linea alba in the case just referred to. I avail myself therefore of the opportunity to modify my criticism in the paper read at Chicago, upon the opening of the abdomen at the outer border of the rectus muscle, and fully realize its advantages in operating for appendicular extravasation.

The great advantage of the several steps consists in adapting the extent of the operative procedures to the nature of the case. If there be a doubt in the diagnosis of appendicitis it is solved by a transverse incision in the iliac region, and if nothing be revealed requiring further surgical interference, the opening may be closed by suturing the peritoneum with catgut in continuous form, while the fascia, muscles and skin are brought together by interrupted sutures of iron-dyed silk. There will not occur much strain upon the suture in this line of union, and the operation should not be carried further except when the evidence of disease in the adjacent structures demands a larger field of observation. Incisions along the linea semilunaris upward or downward, with the turning aside of the corresponding flaps, will afford ample scope for operation in cases of circumscribed abscesses in general peritonitis, resulting from the perforation of the appendix vermiformis.

It has been my object in this paper to direct attention to the early development of inflammation in the structure of the appendix, as its progress and termination in perforation have proved serious in most cases; and the intractability of the consequences produced by extravasation of its contents, as manifested by suppuration and peritonitis, is generally recognized by surgeons.

I am not prepared to assert that a differential diagnosis of appendicitis can be assured prior to perforation, but a reasonable presumption in favor of the seat of the disorder being in the structure of the appendix, may be reached by a careful examination of the local signs and the general symptoms. In view of the strong probability of the existence of appendicular trouble it is asserted that an exploratory operation is justifiable in

[1] Medical and Surgical Reporter, April 30, 1887.

advance of any indications of perforation, thus choosing the lesser evil of an unnecessary incision, rather than risk the greater in the calamatous results of extravasation of the contents of the appendix into the peritoneal cavity, accompanied by shock and followed by septicæmia.

The difficulties which the surgeon must encounter from delay in resorting to an operation until perforation assures him of its necessity, should warrant him in forestalling the danger by an exploratory incision so soon as he becomes impressed with probability of appendicular inflammation; and if this belief is realized, the exploratory operation is made a radical operation.

THE POST-NASAL SYRINGE A CAUSE OF MIDDLE EAR DISEASE; WITH AN ILLUSTRATIVE CASE.

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Notwithstanding the fact that a warning note has been sounded from more than one source concerning the disastrous consequences to the middle ear that may result from flooding the naso-pharyngeal space with fluids, medicated or otherwise, the numerous journal reports, together with the recommendations in many of the recent special treatises, particularly foreign publications, on diseases of the rhino-pharynx, attest to the recklessly indiscriminate employment of methods of this character for cleansing and medicating the nasal and pharyngeal cavities.

The first to call attention to the occurrence of otitis media following the use of the nasal douche was Dr. D. B. St. John Roosa, of New York, who, in 1869, reported[1] an example of acute suppurative inflammation of the middle ear with ulceration of the membrana tympani arising in this manner; and then later, with an amplification of this case, he published[2] a table of sixteen instances of middle ear disease produced by the douche, occurring in the practice of different surgeons. At the same time he gave admonitory advice against the rough or careless use of the posterior nares syringe in acute or subacute catarrh, instancing an example of acute aural catarrh with drum perforation occasioned thereby; and since then these statements have been confirmed by numerous observers, who have noticed and recorded similar facts regarding both the douche and the syringe.

It is true, however, that not a few rhinologists believe these views to be erroneous, asserting that the douche, besides being a most useful appliance in the treatment of rhino-pharyngeal diseases, when properly and carefully handled is entirely devoid of ill effects, and this opinion they support by a weighty array of statistics; but, it must be conceded that there is already on record a sufficient number of such mishaps in the hands of prudent and skilful surgeons to demonstrate that this and like measures are not so positively innocuous as is claimed by their advocates.

The subjoined case is an additional illustration of this fact, and is of especial interest since it shows that the post-nasal syringe, although fully recognized as not altogether harmless—but, at the same time, considered quite safe in comparison with the douche—is an instrument which must be employed with the utmost caution and circumspection.

Sallie ——, a little girl of 12 years of age, who had been under my professional care at intervals during a period of two years for a chronic rhino-pharyngitis associated with middle ear catarrh, reapplied in January, 1887, on account of a slight return of the nasal and aural symptoms. She now received, as formerly, the usual treatment by sprays, powders, etc., each application being preceded, of course, by inflation of the Eustachian tubes, and the use of an alkaline cleansing solution applied by means of the ordinary post-nasal syringe.

The syringe had been employed in this manner a great many times without any unpleasant effects whatever, although no especial precaution had been observed in its application. At 11 A.M., on January 20, I proceeded to cleanse the nasal spaces in the same way, using for this purpose Dobell's solution with "Listerine." At the instant the fluid was discharged from the syringe she complained of a sharp, cutting pain in the left ear, which caused her to cry out, and clasp with her hand the painful ear. The fluid was injected slowly and gently, not forcibly, but I noticed that there was a decided spasmodic action on the part of the pharyngo-palatal muscles which tightly grasped the extremity of the syringe. The intensity of the pain subsided in a few moments, but a dull, heavy ache remained until after the use of a hot water douche; and examination revealed an injected and congested drum

[1] *Archives Ophthalmology and Otology*, Vol. 1, No. 1.

[2] "Practical Treatise on Diseases of the Ear," fifth edition, p. 296, 1881.

membrane, but no bulging. She remained in my consulting room until all pain had disappeared, when she was sent home with instructions to summon me upon the slightest recurrence of suffering. This was not obeyed, however, and I learned that the pain returned in about an hour after leaving my office. This, at first, was throbbing in character, accompanied by a full, heavy sensation in the face and head on the affected side, and becoming exquisitely intense as evening approached. Her mother employed opium, both internally and locally, hot fomentations, etc., but with very little relief until after daylight when the pain suddenly began to lessen and was quite gone within a half hour. Coincident with the subsidence of the pain she noticed a sanguineous discharge, which saturated a plug of cotton-wool, placed in the meatus to retain the anodyne applications, and trickled down upon the pillow. I saw her at midday (January 21), when a small quantity of half-dried bloody fluid was found in the external tube, and a rent in the posterior and inferior quadrant of the membrana tympani plainly visible.

Active measures were immediately taken, and very fortunately the case went on to complete recovery: the perforation healed rapidly, hearing soon rose to the normal, and within the space of a few weeks there was nothing to indicate the occurrence of the accident.

The injurious action of the douche is rightly attributed by Dr. Roosa to the direct passage of a flood of liquid into the tympanic space; but he evidently considers the syringe as harmful only through its irritative or abrasive action to the pharyngeal mucous membrane around the tubal openings—the inflammation thus originating extending along the Eustachian tube to the tympanum —as is shown by the following paragraph, referring to its use: "In cases of acute inflammation of the pharynx attended with considerable swelling, it should be used with care, or it will abrade and irritate the mucous membrane of the pharyngeal wall. This abrasion may then lead to an extension of the inflammation along the tube to the tympanic cavity. *In chronic cases I have never seen or heard of any harm being done by the posterior nares syringe.*"[3] The italics are mine.

In the present instance the acute aural catarrh was undoubtedly the immediate result of the entrance of liquid into the cavity of the tympanum, since the sudden sharp pain at the moment of injecting the fluid can be explained in no other rational way.

It is very clear, therefore, that the naso-pharyngeal syringe may be productive of harm in both acute and chronic cases, and by two methods: first, the direct entrance of liquid into the Eustachian tube and tympanum; and, second, an irritation or abrasion of the mucous membrane around the faucial extremity of the tube, produced by the syringe nozzle, leading to an inflammation which quickly advances along the canal to the sensitive and repellent tympanic cavity.

Whilst I do not wish to be understood as absolutely condemning the posterior nares syringe as an instrument which should be discarded from the armamentarium of aural and pharyngeal appliances, I am desirous of emphasizing the necessity of exercising the greatest care and gentleness in its employment, and, also, of restricting its use to a much fewer number of cases. When it is used, it should never be emptied of its contents with a jerk by suddenly and forcibly driving the piston home, but the liquid should be gently and slowly discharged in a continuous stream; and should a spasmodic grasping of the syringe point take place, the instrument should be either withdrawn entirely, or allowed to remain quietly in position until the pharynx becomes tolerant of its presence, or, perhaps, local anæsthesia of the pharynx may be resorted to with advantage.

Leaving out of consideration the practical lesson furnished by this case, I am opposed on general anatomical and physiological grounds to flooding the nasal and pharyngeal spaces with any considerable volume of liquid; and, furthermore, I am convinced that the spray is the only sensible and effective method by which these cavities may be safely cleansed or medicated.

N. E. cor. Joachim and Conti Streets.

[3] "Treatise on Diseases of the Ear," p. 291.

—At a recent meeting of the Agricultural Society of Paris, M. Torney, professor of arboriculture, put in a note on sewage water. He thinks that the culture of the Jerusalem artichoke would suit very much better than that of any other ordinary vegetable for the rapid absorption of matter in suspension in sewage water. The Jerusalem artichoke attains a height of eight to ten feet, which does not admit of the wind getting to substances on the surface of the soil, and so prevents to some extent the propagation of epidemics.

LOCAL APPLICATION OF BALSAM OF COPAIBA IN INFANTILE LEUCORRHŒA.

BY J. B. JOHNSON, M.D.,
WASHINGTON, D. C.

Leucorrhœa is common to women of all ages. That of young female life is most commonly limited to the vulva; and it is the exception for the inflammation which excites the discharge to extend far into the vagina. When the inflammation does reach into the vagina, the disease is usually quite severe, and is attended with a copious discharge and swelling of the vulva, accompanied by heat, pain and distressing itching. When the labia are separated with the fingers, the mucous membrane, not only of the labia but of the mouth of the vagina, will be seen to be intensely red, tumefied and covered with an unhealthy looking muco-purulent discharge, varying in color from a white to a yellow or greenish hue, and resembling in external appearance the discharge of gonorrhœa. This resemblance of the leucorrhœal discharge to that of the gonorrhœal, sometimes gives rise, in the minds of parents, to the supposition that their child has been criminally dealt with; but such an impression will be easily dispelled not only by the history of the case, but by the absence of marks of injury from criminal violence, which when present usually cause rupture of the hymen, bruising and swelling of the labia and surrounding parts, attended with a more or less copious trickling of healthy blood from the wounded tissues of the external genital organs.

The most common exciting cause of the disease I have found to be an herpetic or eczematous eruption about the vulva, which, in consequence of the intense pruritis excited by the presence of these eruptions, forces the child to scratch and rub her parts with violence, creating not only much irritation to the vulva but also to the vagina. This repeated and excessive rubbing of the external organs of generation by the child with her hands, is often the first sign which leads the mother to investigate the cause of the child's uneasiness; and upon examination the mother generally finds the labia red and swollen, and covered with scaly incrustations of the dried discharge, and upon separating the lips of the vulva she will see purulent or muco-purulent matter issuing from the vagina, and the presence of the disease is thus ordinarily detected and confirmed. Scrofulous girls are most susceptible to this disease. It sometimes occurs during or follows an attack of scarlet fever, and does occasionally arise from cold and from infection. During its progress it is much aggravated or prolonged by the existence of dentition, worms or constipation. Its predisposing cause resides in an innate liability to inflammation of the mucous membranes, which is now and then seen to be a part of the constitutions of some individuals. As there are persons born to great liability to inflammation of the serous membranes, so there are those who come into the world with a high susceptibility to inflammations of the mucous membranes; and it is this diathesis that explains why a child may have infantile leucorrhœa from "*cold*," caused by insufficient clothing of the lower extremities, or from sitting on the damp ground, or upon cold surfaces of door steps or stones.

The discharge is highly contagious, and a healthy girl child may be infected by sleeping with one who has the discharge; and a child so affected should not be allowed to sleep in the same bed with another child or even with its own parents, for instances have been known of mothers being infected by sleeping with their little daughters while suffering with the disease, which often maintains a tedious course of several weeks or more. The cloths and towels used to dry the parts of girls thus affected, should never be used to wipe the face, or indeed any part of the body; for if the slightest portion of the discharge should get into the eyes, acute and dangerous ophthalmia is almost certain to be excited. In order to guard against such accidents, the mother should always be informed of the activity of the contagious character of the discharge of infantile leucorrhœa.

Treatment.—This disease will persist in being very tedious in its course, if absolute cleanliness and partial rest are not firmly insisted upon during the application of the remedial measures which may be adopted for its cure. The mother should be instructed to wash well the external genital organs of the child at least four times a day; and this cleansing should be performed in the morning as soon as the child gets up, and at noon and evening, and just before the child goes to bed. As a wash for this purpose, I usually order the following, to be used tepid, in cold weather:

℞ Pulv. borax.....ʒij
Water.....f ʒv
Glycerine.....f ʒj
Carbolic acid.....gr.x.

M. S.—Shake well and use four times a day.

After the parts have been well washed, I order finely powdered oxide of zinc, or oleate of zinc, to be freely sprinkled, or powdered between and over the lips of the vulva. Ordinarily, I find this simple treatment to cure the case; but unfortunately, the disease often extends from the vulva far into the vagina, giving rise to severe vaginitis; and when I meet with a case in this condition, I am in the habit of relying upon the local application of balsam of copaiba for its cure. After each washing, I direct three or four drops of the copaiba to be dropped into the mouth of the vagina, and allowed to remain there, and to diffuse itself over the various parts of the vulva. The dropping of the copaiba into the vagina should be conducted while the child is lying upon its back, with its hips elevated by a pillow, and the labia majora separated as widely as possible; and the child should be allowed to remain in this position for five or ten minutes after the application of the copaiba. Should the pure copaiba excite too much irritation, it may be mollified by mixing with equal portions of cocoa-butter or carbolized vaseline, and put into the vagina with a camel's-hair-brush as far as this is practicable. While the local treatment is in progress, I prescribe the following as a tonic and alterative:

℞ Sulph. magnesia.....ʒj
Caraway water.....f ʒviij
Iodide of potassium.....ʒij
Fowler's solution.....f ʒj

M. S.—Shake well and give one teaspoonful to a tablespoonful, three times a day, according to the age of the child.

When severe pain in micturition attends the discharge, it will be found to be caused by fine inflamed points of mucous membrane situated about the orifice of the urethra, and these projecting points are most quickly destroyed by the application, once in every two or three days, of nitrate of silver. During treatment, the child should not be allowed to go to school, and should be restricted in its usual exercise. Indeed, the less exercise the child is allowed to take, the sooner will a cure be attained; and this fact should be impressed upon the mind of the mother; and she should also be informed that the treatment should be continued in a less rigid manner for several weeks after the discharge has disappeared; for if this rule is not observed, the discharge will most certainly return after its apparent disappearance. The diet should be generous and nutritous; while those articles of food apt to irritate the alimentary canal should be strictly forbidden.

DEATH AFTER ADMINISTRATION OF CHLORAL IN LABOR; FIRM CONTRACTION OF THE UTERUS.

BY JACOB R. LUDLOW, M. D.,
EASTON, PA.

A woman, about eighteen years of age, primiparous, came under my observation some time ago, suffering from puerperal eclampsia at full term. She had been bled from both arms, had taken chloroform inhalations, and, during the night, two rectal injections of chloral hydrate—at least eighty grains in the two injections.

When I saw her the next morning, she was pallid, entirely unconscious, with a small, feeble pulse—about 120, with shallow, frequent, noiseless respirations, and extreme contraction of the pupils. There was very great œdematous swelling of the lower extremities. Finding the os dilatable, I produced podalic version, and in about thirty minutes delivered a large male child, still-born, flaccid, with the appearance of having been dead some hours. I operated slowly, regardless of the life of the child, fearing to encounter atony of the uterus with immediate fatal hemorrhage; but the uterus contracted firmly and the secundines came away without trouble. After the delivery she did not manifest any noticeable change. She seemed in good condition except for the extreme anæsthesia.

I saw her by request the next morning, about twenty-four hours after her delivery. Her condition was unchanged, still pale, with pulse and respiration as when I left her the previous day, perfect unconsciousness and loss of voluntary motion, the conjunctival reflex and deglutition abolished. The uterine globe was firm and distinct, and there had been absolutely no leakage. The œdema of the legs was considerably diminished. She was ordered whiskey per rectum, but died the following night, about thirty-six hours after delivery.

Perhaps the most noticeable thing in this case is the lethal anæsthesia, with abrogation of deglutition, voluntary motion and consciousness, with cardiac and respiratory centres almost paralyzed, and this persisting continuously for more than thirty-six hours; while yet the innervation of the uterus was unaffected and the womb retained its tonicity to the last.

I think it is fair to infer from it that chloroform and chloral hydrate do not in any degree impair the power of the centres which give energy to the uterine contractions.

Society Reports.

PHILADELPHIA COUNTY MEDICAL SOCIETY.

Stated Meeting, April 11, 1888.

The President, J. Solis-Cohen, M.D., in the Chair.

Dr. J. M. Barton read

A Report, and Exhibited the Specimens, of Some Cases of Abdominal Surgery.

By invitation of the Board of Directors of the Philadelphia County Medical Society, Dr. Barton submitted some specimens from cases of abdominal surgery and presented the notes of them:

"*Case I.—Abscess of liver. Free incision and drainage; recovery.*—George B., aged thirty-eight years, was admitted to the medical wards of the Jefferson Medical College Hospital, July 29, under the care of my colleague Dr. Neff. The patient was suffering with an immense abscess of the liver, extending the area of the percussion dulness to below the umbilicus and to the left of it. At the request of Dr. Neff, I removed by aspiration more than a quart of "brick-dust" colored pus, with such relief that the patient was able to return to his home in the interior of the State. The abscess cavity rapidly refilled, and he returned to the hospital, when we decided to operate by the method of Dr. Ransohoff, of Cincinnati: making an incision through the abdominal wall, five inches in length, at the outer edge of the right rectus muscle, permitting it to gape, fastening the edges of the wound by sutures to the liver, and when firm adhesions had taken place, opening the liver by the galvanic knife. When adhesions were found to have formed, and I attempted to divide the tissues of the liver with the galvanic knife it did not act well; at first, while white-hot it would cut readily, but the resulting very free bleeding quickly short-circuited the current and the knife became instantly cold. After repeated trials it still proved so unsatisfactory that an ordinary scalpel was substituted, with which the pus cavity was reached. An attempt to check the bleeding from the margins of the incision, by the cautery knife, was also unsuccessful, and it was only by filling the wound with a number of rubber catheters, which happened to be at hand, that the hemorrhage was controlled.

The abscess cavity was washed out daily with various antiseptics; it gradually closed, and the patient was discharged cured. When Dr. Neff saw him the following December, his weight was one hundred and fifty-six pounds, his pulse beat eighty to the minute, and he had no evidence of hepatic disease."

Case II.—This was a case of epithelioma of the œsophagus, in which gastrostomy was done and death resulted. The patient was a man 42 years old.

Case III.—This was a case in which an unmarried woman, 36 years old, had a large uterine fibroid. On making an exploratory incision it was found that universal adhesions would prevent the removal of the uterus or of the ovaries. The patient recovered.

Though previous to the operation she almost invariably bled for ten days at each menstrual epoch and at least twice between the menstrual flows, immediately after the operation the excessive bleeding ceased, and for nearly two years she regularly menstruated but three or four days; she did not lose more than one-fourth of the quantity each day that she had prior to the operation and there was no bleeding whatever between the menstrual periods. Her pains have ceased since the operation, her general health has greatly improved, and she looks much younger. Ever since the operation she has been, and is now, following her occupation as a school-teacher. Nothing was done at the operation to account for this improvement, which is great enough to have been considered quite a success if the ovaries had been removed. The tumor is gradually increasing in size, and is now beginning to interfere with respiration.

"The next case is one of so much interest that I am anxious to have it on record, though the principal part of the operative treatment was not performed by myself. The laparotomy was performed by my colleague, Dr. F. H. Gross, when I was a member of the staff of the German Hospital, during his term of service; the herniotomy by myself during my term, though we were both present, and took active part in both operations. I am indebted to Dr. Gross for permission to report this case:

"*Case IV.—Strangulated hernia. Operation; loss of nine inches of intestine; subsequent laparotomy; several feet of bowel found obstructed by inflammatory deposits; bowel above the obstruction joined to bowel below the obstruction; recovery.*—Frank F., aged 18 years, was admitted to the German Hospital on the evening of March 3, 1884, with a strangulated right inguinal hernia of eighteen hours' duration. On opening the sac of the hernia nine inches of the bowel was found to be in a sloughing condition. The ring was nicked, the healthy ends of the bowel

made to protrude, and the gangrenous portion incised. We proposed, on the next day, to freshen the edges of the healthy bowel and bring them together. By the following morning the patient had developed an intense peritonitis with a temperature of 104°, and the operation was postponed. After a week of severe illness he recovered, the sloughing bowel having separated in the meantime.

Some weeks later, as he was slowly emaciating, and the discharges looked as though the artificial anus was high up the bowel, operative interference was decided upon. The wound was enlarged, directly upward, at first but slightly, but ultimately to the extent of several inches, for the purpose of joining the divided ends of the bowel.

In the neighborhood of the artificial anus from two to three feet of intestine were found, strongly matted together by inflammatory deposits; small projecting loops of a few inches in length were found free with both ends terminating in the mass. The lower end of the bowel, from which the slough had separated, could not readily be distinguished from any of the other loops; and it soon appeared that it would be useless to join it to the bowel which formed the artificial anus, as it was completely obstructed at many points. As the colon was free, and a few inches of the ileum, at the suggestion of Dr. Weed, then one of the resident physicians, it was decided to join the bowel forming the artificial anus to the colon. For this purpose a small opening was made in the cæcum, and one blade of Dupuytren's enterotome introduced, the other being carried into the bowel forming the artificial anus, and the two blades clamped together. A temporary ligature was placed around both intestines while the toilette of the peritoneum was made; they were then fastened in position, and the wound, about six inches in length, closed.

The patient did well after the operation, though it was found necessary to reapply the enterotome twice before a satisfactory opening was obtained, three times in all. The fæcal fistula rapidly contracted, and when I last saw him he was able to wear a pad over it for a week without removal; his bowels acted naturally, he was free from pain, gaining flesh, and was working as elevator boy at the hospital.

I heard afterward that another surgeon had attempted, though unsuccessfully, to close the fistula."

Case V.—This was a case in which a married woman, fifty-four years old, had an ovarian cyst which ruptured. Ovariotomy was performed, and the patient died on the fourth day.

Case VI.—This was a case in which a man, thirty-one years old, had an encysted pelvic abscess. The abdominal and visceral peritoneum were stitched together, the abscess emptied and drained, and the patient recovered.

Case VII.—In this case double ovariotomy was performed on a married woman, twenty-eight years old, for multilocular cysts, weighing about forty pounds. The patient recovered.

Case VIII.—In this case a large fibroma of the uterus was removed from a married woman, thirty-two years old. The uterus and ovaries were removed by abdominal section, and the patient died on the fourth day.

"*Case IX.—Stricture of the ileo-cæcal valve, chronic obstruction of the bowels. Laparotomy; digital dilatation of the stricture; recovery.*—Mrs. Ann H., aged thirty-seven years, a patient of Dr. D. S. Jones of Plymouth, Pennsylvania, was admitted to the Jefferson Medical College Hospital in May, 1887. She had been in good health until the birth of a child in May, 1886. Since then she had had repeated and increasing attacks of obstruction of the bowels; during which there were entire loss of appetite, obstinate constipation, constant vomiting, great abdominal pain, and tenesmus, similar, she stated, to labor pains. Lately there had appeared at these times a tumor about the size of the adult fist in the lower part of the abdomen; these attacks occurred about once a month, and as they lasted three weeks she had but a short interval of comfort between them. When free from the attack, she stated that the tumor returned to the right iliac fossa, where she thought she could distinguish it by palpation and by its tenderness on pressure. I was unable, at this time, however, to recognize any unusual mass in this situation.

I kept her under observation until an attack should occur. On May 21 an attack began, and her sufferings fully verified her statements. The tumor appeared between the umbilicus and the pubes, it was about the size, and very nearly the shape, of the adult kidney.

On May 2, 1887, in the presence of Professors Gross, Parvin, Brinton, and several other physicians, I made a median incision about four inches in length and exposed the mass; it proved to be an intussusception of the ileum into the colon with a thickened and contracted ileo-cæcal valve forming the apex of the intussusception. There were

slight adhesions between the contiguous layers of peritoneum covering the bowel, which were readily broken up, and the intussusception reduced. On examining the ileo-cæcal valve by a finger invaginating a fold of the colon, it was found to be hard and contracted. A longitudinal incision was made in the colon about one inch in length, and three from the valve, through which I passed my finger and found the valve contracted to about the size of a crow's quill (one-fifth of an inch). It was slightly thickened, quite hard, white in color, and did not bleed during the examination or subsequent manipulations. It was considered by all present to be a case of cicatricial stenosis due to some previous inflammatory action, and certainly not malignant. It was dilated, with considerable difficulty, by the introduction of the little finger, and the index finger was then carried through its entire length.

The wound in the bowel was closed by a continuous silk suture, including only the mucous membrane; the peritoneal coats were brought in apposition by a continuous silk Lembert suture.

All the operative procedures upon the bowel were performed outside of the abdominal cavity, the abdominal wound being kept closed by sponges. The portion of bowel outside was thoroughly washed and returned, the abdominal wound was closed in the usual manner.

There was some vomiting after the operation; the patient was kept slightly under the influence of morphine for a few days, and on a milk and broth diet. The bowels opened naturally on the eighth day, the stitches were removed on the fifth and sixth days; the temperature never rose above 100°. She returned to her home entirely free from all her previous symptoms, and remained free for several months."

[For her subsequent history, see Case XIII, page 600].

"*Case X.—Obstruction of the pylorus. Digital dilatation by Loreta's method; death from exhaustion.*—George H., German, aged fifty-eight years; blacksmith. His health had always been good until the last year. At the time he came under my care he had the typical symptoms of complete pyloric obstruction, with a well-marked tumor at the usual situation. It was not very large nor hard, had no marked outlines, and presented the characters of pyloric thickening more than those of a malignant growth. The microscopical examination of the matters vomited gave no evidence of malignancy, and no vomiting of blood had occurred. He was greatly emaciated, and so feeble that at first I refused any operative interference; the operation had, however, been explained to him, and its performance promised before he came under my care, and he insisted so strongly on having a chance for prolonging his life that I consented.

The operation was performed at Jefferson Medical College Hospital May 22, 1887, in the presence and with the assistance of Professor Brinton, Dr. Wirgman, and quite a number of others.

As the patient's condition warranted no further interference than mere dilatation of the pyloric orifices, and as the usual incision to the right of the median line would have exposed the stomach nearer to the pyloric orifice (as shown by the position of the tumor) than I desired, I made the incision directly in the median line, and about three inches in length, beginning an inch and a half below the ensiform cartilage.

The stomach was readily exposed three inches from the pylorus. The examination of its exterior threw no new light on the character of the growth, though the stomach at this point was found to be slightly adherent to the structures beneath. An incision, a little over one inch in length and three inches from the pyloric orifice, was made in the stomach, parallel to and directly beneath the abdominal incision; the coats of the stomach were much thickened. Complete stenosis of the pyloric orifice was found when the finger was introduced, but this was readily dilated with the little finger. While the tumor was supported outside the abdominal walls with the left hand, the orifice was then further dilated with the index finger.

The thickening and infiltration of the walls of the stomach at the point of incision prevented the use of the Lembert suture; their softened condition evidently required the suture to pass through all the coats. As the abdominal wound was directly over that in the stomach, the latter was closed and brought in contact with the abdominal wound, so that the visceral and parietal peritoneum might adhere, and if any of the contents of the stomach should escape or any pus form, they might readily drain outside and not into the general peritoneal cavity. Fine silk with two needles were used, these were carried from within outward through all the coats of the stomach, one needle through each lip, then crossed and one brought through each lip of the abdominal wound; a few were carried direct without crossing. These sutures were tied and the abdomen closed.

Nothing was given by the stomach for the first twenty-four hours, the rectal nourishment upon which he had relied previous to the operation being continued. No vomiting occurred during the four days that he lived. On the second day milk and hot water were given in small doses at regular intervals, and as they were well borne they were increased in quantity and frequency. Notwithstanding the fact that he took over a quart of milk per day, besides rectal nourishment, he sank and died exhausted on the fourth day after the operation. There had been no elevation of temperature.

At the autopsy the stomach was found firmly fastened to the abdominal wall; there was no evidence of any peritonitis. In the interior of the stomach it was difficult to find the point at which the incision had been made, the sutures being completely buried in the folds of the mucous membrane. The pyloric thickening was inflammatory in character, and not due to any malignant growth.

There was complete obstruction previous to the operation, there was none after, and had the patient been subjected to operative interference earlier there is no reason why his life might not have been greatly prolonged."

"*Case XI.—Ovarian tumor. Removal; recovery.*—Miss A., aged thirty-eight years, had noticed a pain less abdominal enlargement for a few months. On examination I found a small ovarian cyst, lying in the median line and rising slightly above the umbilicus. On May 23, 1887, with the assistance of Drs. Da Costa, Edward Graham, Sweet and Fisher it was removed. The incision was about three inches in length, the tumor was non-adherent. It was tapped, drained, and removed in the usual manner; its pedicle was tied with silk and dropped.

The peritoneum was brought together with chromicized catgut, the interrupted silk suture being used for the other tissues. The patient made an uninterrupted recovery, her temperature never rising above 99°. The tumor weighed about fifteen pounds."

"*Case XII.—Two penetrating stab wounds, one puncturing the liver and one the transverse colon. Laparotomy; recovery.*—Michael H., aged twenty-five years, was admitted to the Jefferson Medical College Hospital at 3 P.M., of September 9, 1887. About three hours previously he had been stabbed twice with a small and pointed amputating knife, during a quarrel in a house of ill-fame.

There were two wounds, both penetrating the abdominal cavity, both at the outer edge of the right rectus muscle and both running diagonally toward the median line, and penetrating the peritoneum at that point. The upper was one and a quarter inches long and was just below the edge of the ribs; it terminated in the left lobe of the liver, and from it there was free venous bleeding.

The lower wound was three-quarters of an inch long; it was three inches below the upper and just above the level of the umbilicus. After hurried antiseptic preparations, I opened the abdomen in the median line from the ensiform cartilage to the umbilicus, and found an opening about five-eighths of an inch in length in the transverse colon parallel to its length and near its mesenteric attachment; this was closed by the continuous silk Lembert suture. The suture failed to control a small artery in this wound, but a separate stitch carried under it and tied secured it.

The wound in the liver was small, it had ceased oozing, and as its lips were in fair contact no suture was used. The abdomen was cleansed, the wound closed and dressed in the usual manner.

The following morning his temperature was 101° and in the evening 100°; after that, though it kept quite low, varying from 98½° to 99°, he had a sharp attack of peritonitis, lasting three days, during which time there was constant regurgitation of bloody fluid. The abdomen was painful and greatly distended with gas, requiring the constant use of the long rectal tube to relieve him. The stitches were removed on the fourth and fifth days, and the abdomen supported by adhesive plaster. He was discharged cured on September 29, having been in the hospital twenty days."

"*Case XIII.—Epithelioma of the ileo-cæcal valve. Resection of three inches of intestine; recovery.*—Mrs. H., aged thirty-eight years, the same patient whose ileo-cæcal valve was dilated seven months before (see Case IX, page 598), came complaining of a return of her former symptoms; her sufferings were slight, but were evidently of the same character as before the first operation.

November 1, 1887, with the assistance of Drs. Allis, Kendig, Stillwell, and the resident staff, I again opened the abdomen. A straight incision parallel with the median line was made; it was three inches in length terminating at a point one inch outside the middle of Poupart's ligament. The incision was made at this point as the nearest to the portion of bowel I wished to attack, because I feared adhesions might have formed after the last operation, rendering it inaccessible from any distant incision; and, further, if it became necessary to form an artificial anus, it would be a convenient point.

I had decided that if it should prove to be a recontraction of the stricture, to make a longitudinal incision about two inches in length carried through the ileum, ileo-cæcal valve, and cæcum, bringing the two ends of the wound together and sewing it up transversely; this would best be made on what would be the under surface of the bowel when the patient stands erect. I tried this on the cadaver and found it practicable, and that it increased the circumference of the bowel, at that point, about two inches. The head of the colon was readily found, there was no return of the intussusception, no no adhesions had formed, though in reducing the intestine at the first operation there had been slight bleeding at a number of points at which adhesions were torn. The scar of the original intestinal incision was scarcely perceptible. At the ileo-cæcal valve, however, there was now a decided tumor, and it was now evidently epitheliomatous. An incision was carried into the mass and verified the diagnosis. The entire valve had become an irregular mass of epitheliomatous tissue varying in thickness from a half an inch to an inch, entirely obstructing the gut except an aperture in the centre, about one-third of an inch in diameter. The circumference of the valve was less thickened by the disease than the centre. The abdominal wound was now closed by sponges, leaving the diseased parts outside; three inches of the bowel, including the disease, were removed; no clamps were used, the bowels being held in the hands of an assistant; a few vessels were tied.

As the mortality is very high when the separated ends of the bowel, in these operations, are sewed together and returned, I had decided if it became necessary to excise, to establish a temporary artificial anus and begin at once the proceedings for its cure. With this end in view, immediately after the removal of the diseased bowel and the ligation of the bleeding vessels, one blade of Dupuytren's enterotome was introduced into each portion of bowel, viz., one into the ileum and one into the colon, the two blades were brought together and the screw run down firmly. A strong ligature was placed on the ends of the bowel, including the enterotome, to prevent the escape of fæces during the subsequent manipulations. The bowel was washed, placed in position at the lower angle of the wound and fastened there with a continuous silk suture. The abdominal wound was closed, covered with cheese cloth saturated with mercurial solution, and this in turn with patent lint soaked in sweet oil. This is the best method that I have found to protect abdominal wounds close to an artificial anus. The heavy ligature around the ends of the bowel was now removed. A ring of cotton soaked in oil was placed around the artificial anus, the outer extremity of the enterotome supported by oakum, and a wide bandage pinned over it. Morphine was used hypodermically during the first forty-eight hours and then discontinued; vomiting occurred during the first two days and then ceased. Some fæces appeared on the evening of the operation, and full quantities two days later. On the eighth day the enterotome was found loose, and was removed; its removal was preceded by a passage of fæces from the natural outlet. The stitches were removed on the third and fourth days, and the wound supported by adhesive plaster. After the removal of the clamp the patient was permitted to rise, and all restrictions removed from her diet.

The bowels acted naturally for a few times, when all the fæces came again from the artificial anus. The clamp was again applied on the 17th, and came away on the 28th. Its removal was again followed by a few natural passages. As these ceased in a few days the clamp was applied for the third time with a precisely similar result. As this had proved ineffectual, the method of Mr. Banks, of Liverpool, was used. A strong ligature was fastened to the middle of a heavy piece of rubber gas tubing about six inches in length; one end of the tube was passed into one bowel, the other end of the tube into the other bowel, the middle of the tube pressing against the spur. The position of the bowel in this case was such that the rubber tube was retained with difficulty. After trying it for ten days without success, I substituted the apparatus which I here show, consisting of two pieces of very heavy rubber gas tubing joined together like the letter **T**. The upper part of the **T** is about one and a half inches long, and presses directly against the spur; the other tube is three inches long, and merely serves to keep the first in position. The large base is circular, is three inches in diameter, and serves as a pad to prevent the escape of fæces from the artificial anus. The three pieces of rubber are joined firmly by a strong wire running from the first to the last piece, and twisted tight. This method proved at once satisfactory, and a large proportion of the fæces began at once to pass by the natural outlet, and continued to do so. The patient is now in the hospital, but I shall make no attempt to close the fistula until it is seen if the bowels will continue to act naturally.

During this prolonged treatment, fearing that the colon, from disuse, might contract, I directed that she should be given an injection of a quart of water daily, and I was surprised to hear that when a pint had been given it appeared at the artificial anus. By continuing these injections the capacity of the colon was rapidly increased, and when last tried it held three pints; of course, when the bowels began to act naturally this was discontinued."

"*Case XIV.—Chronic obstruction of bowels by encephaloid tumor. Exploratory laparotomy; artificial anus established; recovery from the operation; death fourteen days later from obstructive peritonitis arising from tumor.*—Francis O. B., aged thirty-eight years, Irish, carpet porter, a patient of Dr. James Robinson, with whom I saw him January 18, 1888. He was in perfect health until June, 1887, when he began to have slight cramps, once or twice daily, and occasionally at night, in the left iliac fossa. He continued working until December 24, 1887, and has been confined to bed since. His attacks had not increased greatly in severity, but he was getting much weaker. He had lost fifty pounds in weight; he vomited once or twice a week; it was not stercoraceous. He suffered greatly with tenesmus, which produced from ten to fifteen passages during the night, each being a small, hard, white mass about the size of a cherry.

The left iliac fossa was slightly tender. The abdomen was distended with gas. The pulse was 104, and the temperature normal. His pain was uninfluenced by food. He had never passed blood by the bowel. The rectum was found empty and unobstructed.

Later I removed him to Jefferson Medical College Hospital, by which time his pain was nearly constant, and he was unable to sleep without large doses of morphine. Some days after admission his temperature increased to 103°; there was increased abdominal tenderness and other evidences of a slight attack of peritonitis, which disappeared in forty-eight hours. On the 28th he passed wind by the penis, and again on the 30th.

On January 30, 1888, with the assistance of Drs. Allis, Nancrede, Robinson, and the house staff, I opened the abdomen. A median incision about four inches in length was made, and a lobulated tumor the size of an orange was found in the angle between the bladder and the spine. The sigmoid flexure of the colon was tightly adherent to and partly buried in the tumor. The cæcum was carried toward the median line, and was also adherent to the tumor. The lower end of the ileum was closely adherent, and its calibre nearly obliterated.

The colon was contracted and collapsed; all the bowels above the point of obstruction in the ileum were greatly distended.

As nothing could be done with the growth, a fold of the ileum a few inches above the point of obstruction was brought out of the wound and fastened in its lower angle by a few silk sutures; a rubber drain was introtuced, as a glass one failed to reach the desired point, and the abdomen closed. The drain was removed about twelve hours later, as I feared to have it remain in such close proximity to the artificial anus. Twenty-four hours after the operation the fold of bowel in the wound was opened, and the artificial anus established.

On the second day the patient was placed upon his usual food, stimulants, etc. The stitches were removed on the fourth and fifth days; the wound healed promptly. It was successfully kept from contamination by the fæcal discharges, by the method described in a case reported above.

At the operation a fold of bowel was brought entirely out of the wound; this was adopted as a modification of the method of entirely cutting off the bowel, closing the lower end with sutures, and using the upper to form the artificial anus.

The method here adopted has the advantage of rapidity, less danger of contaminating the cavity with fæcal matter, as the opening of the bowel may be postponed until firm adhesions have formed. It permits any gases or other material that may be imprisoned in the lower bowel to escape, and quite as effectually prevents any material passing the artificial anus into the lower bowel.

The patient was relieved of his pain, the vomiting ceased, and he slept well; had a fair appetite, and improved in appearance. All fæcal discharges, and they were very copious, came from the artificial anus, and none by the natural outlet after the first twenty-four hours.

On the thirteenth day there was a slight elevation of temperature, and all fæcal discharges suddenly ceased; injections of warm water carried some distance above the opening by a soft catheter were without effect; by evening vomiting and other symptoms of acute obstruction occurred, and he died twenty-four hours later, or fourteen days after the operation.

The *post-mortem* examination was made on the same day. The abdominal wound was solidly healed; the bowel, at the artificial anus, was firmly attached to the abdom-

inal opening. The abdominal cavity contained quite a quantity of opaque serum; the opacity was greatest near the tumor, and on pressing the tumor, thick, purulent-looking fluid exuded from it. This was probably the orgin of the fatal peritonitis. The bowels were but slightly congested, and only at one point, about twelve inches above the artificial anus, were adherent. The bowel at this point was sharply flexed upon itself, and adherent for about three inches, causing complete obstruction. This adhesion was readily broken down by the finger, and it would probably have yielded to an active saline.

The condition of the bowels, as found at the time of the operation, was verified; the tumor was broken down, and had ulcerated into the sigmoid flexure; a large number of secondary nodules were scattered through the liver. The microscopical examination was made by Dr. Longstreth; the tumor and the nodules from the liver were reported by him to be encephaloid.

MEDICAL SOCIETY OF THE COUNTY OF NEW YORK.

Stated Meeting, April 23, 1888.

The President, Laurence Johnson, M.D., in the Chair.

After the passage of resolutions concerning the death of Dr. C. R. Agnew, the scientific paper of the evening was read by Dr. W. C. Jarvis, entitled,

The Indications for the Surgical Treatment of the Deflected Nasal Septum, with an Analysis of One Hundred Cases.

There were, the author said, definite symptoms and pathological complications easily recognized and explained as being more or less directly associated with deflected nasal septum, and which afforded excellent guides in the treatment of this complaint. Such guides, however, had not been pointed out in any single paper, and it was to supply this want that he addressed the Society.

His cases included only those which had been treated in private practice and of which he had kept the detailed history. In forty-two of the cases the deflection of the septum was to the right, and in forty-seven to the left, while in eleven it was bilateral. Seventy-eight were purely cartilaginous, seventeen were osseo-cartilaginous, five were osseous deflections.

The principal indication for surgical interference was nasal stenosis, which was present in eighty-one of the cases. Among the most important complications which should be recognized from the start as special indications for an operation were hypertrophies of the turbinated bones. These were present in twenty-four per cent. of the cases of deflection to the right, in eight of which an operation was required to remove the redundant tissue; and in twenty per cent. of the deflections to the left, requiring operative interference in four cases. Posterior hypertrophies were present in fourteen per cent. of the cases. Slight redundancies of the turbinated tissue which were present in all cases of deflected septum were not considered. The next most common complication was trouble with the ear, it being present in twenty-nine cases. In some the operation was undertaken for the relief of this alone. The bulk of these were in physicians who recognized the necessity for perfect ear ventilation.

The eye was complicated in a marked manner in eleven cases. Well marked catarrhal headache was present in fifteen cases. Other complications were hay fever, polypi, bronchitis, etc. Hypertrophic rhinitis was present in ninety-four cases; atrophic rhinitis in six.

The stenosis which was so common was in some cases complete, while in others it was incomplete, or alternated from complete to partial. Snoring was common, and while this might occur without stenosis, it was frequently caused by stenosis, and might in persons of delicate health be of serious import. Nasal stenosis was capable of producing pharyngitis, laryngitis and bronchitis. Dr. Jarvis thought it might, under favoring conditions, induce phthisis. It is sometimes caused by a dam-like accumulation of the fluids in the nose, and made an operation necessary to open up the nasal gutters. Some patients had been operated upon unnecessarily, an acute congestion of the turbinated tissues having been mistaken as a symptom of septal deflection. The diagnosis could be made by the lapse of time, use of cocaine and the rhinometer.

Conditions in which an operation was not indicated were named as follows: 1. Extra nasal deflections. 2. Cases in which the septum was deflected, but so far forward as not to interfere with the rise and fall of the turbinated tissue. 3. Deflected non-obstructive septa. 4. Non-obstructive deviations in the nostril exhibiting a pale or normal hue of the pituitary membrane. 5. Slight localized non-obstructive bending of the vomer placed above the level of the nasal floor and occupying the more spacious portion of the nostril. 6. Cases of considerable deflection,

non-obstructive, presenting a smooth regular surface and gentle undulation.

In twenty-four per cent. of the cases the snare alone was employed, in twenty-nine per cent. he used the septum scissors, in eleven, the fracture forceps; in six, the surgical drill, and in thirty the electrical drill.

Dr. Bucklin thought we could not form an opinion as to the amount of space required in the nostril for breathing purposes by a comparison with the size of the lumen of the tube used in laryngeal intubation. There should be room for free play of the mucous membrane covering the turbinated bones, which varied with the temperature in different individuals. He thought nasal stenosis required especial attention as it so frequently led to catarrhal deafness. In the class of cases under discussion there resulted changes in the connective tissue in the nose, attended by the secretion of tenacious mucus. This would not cease immediately after removal of the deflection of the septum, overcoming the stenosis, and for that reason patients had often regarded the treatment as a failure in not overcoming the chief symptom from which they had suffered. He had a patient whose commencing phthisical symptoms disappeared at once after overcoming the stenosis.

Dr. Clarence Rice regarded surgical interference performed gently and by a careful operator as less heroic treatment than the use of swabs and douches so commonly resorted to a few years ago, and still much employed by many who condemned surgical interference.

Dr. Phillips thought the indications for treatment were to enable the person to breathe freely through the nostrils. After an operation the treatment of the wound was of special importance to avoid adhesion of opposing surfaces.

Dr. Tansley had in a number of instances had occasion to treat patients for a suppurative otitis which had been excited by operations upon the nose in patients whose auditory difficulty had not been of an active kind.

Dr. Beverley Robinson favored the use of caustics and the cautery.

—Dr. S. G. Dixon suggests in the *Therapeutic Gazette*, April, 1888, that the usual model of suppositories for the rectum be so changed as to make the present base a short cone. When the suppository is introduced by this short cone beyond the internal sphincter, the contraction of this muscle upon the longer cone will force the entire suppository further up the bowel.

Hospital Notes.

THE TREATMENT OF PUERPERAL SEPTICÆMIA AT THE PHILADELPHIA LYING-IN-CHARITY—WITH REMARKS.

CHARLES P. NOBLE, M.D.,
SENIOR ASSISTANT PHYSICIAN.

The treatment is based upon the principle that puerperal seticæmia is caused by the entrance into the system of an infectious material through lesions in the genital passages. This infectious material is believed to be certain micro-organisms, which produce their effects either directly by their action on the fluids and tissues of the body, or indirectly through certain products of their activity, called ptomaines, or both.

The prime object of local treatment in puerperal septicæmia is to render and maintain the utero-vaginal canal in an aseptic condition. It must be recognized, however, that when once the germs are within the tissues or vessels of the puerpera, they are beyond the influence of local medication. Hence the result to be hoped from local antisepsis is that it will limit the dose of poison to that which has been absorbed before treatment was instituted. The tissues and white blood cells must be left to battle with those germs which are already within the tissues, assisted by constitutional medication. Therefore the results from local treatment are most brilliant in cases of putrid infection, where the fever is due rather to the absorption of the products of decomposition of the lochia, or of fragments of retained placenta or membranes, than to the action of germs on the tissues of the patient.

Other objects to be gained by local treatment are to favor the healing of wounds, and promote the comfort of the patient.

Neither septic abscesses of the pelvic cellular tissue nor pyæmic abscesses have developed in the Charity's cases (within three years), nor has phlegmasia dolens been observed. In two cases gonorrhœal salpingitis has developed *in puerperio*. In one—an outpatient—peritonitis succeeded, laparotomy was done by Dr. Longaker, the diseased tube removed, and irrigation practiced. The patient was *in extremis* before the operation, and died shortly afterward. In one case an old pyo-salpinx induced purulent peritonitis and death, without operation. These cases are mentioned to show the variety of conditions usually classed as "puerperal fever."

Where a diagnosis of puerperal sepsis is made, local irrigation is instituted at once, irrespective of the odor of the lochia. Where the temperature does not exceed 102° F., vaginal irrigation alone is practiced. This is for the reason that infection takes place in the majority of cases through lesions of the vagina or vulva, and only exceptionally from within the uterus. Corrosive sublimate solution (1–2000 to 1–4000) is used. The irrigations are repeated at intervals of three or four hours by the nurse. Where the fever does not subside in from six to eight hours, or increases, the uterus is washed out by the physician himself. This necessitates a digital examination, when bits of placenta or membrane, if present, are removed by the finger. The dull curette has been used to some extent, both for diagnosis and the removal of foreign material from the uterine cavity, and is regarded with favor. But no mere instrument can give the information derived through the sentient examining finger; nor will any inflict so little traumatism in the removal of foreign bodies. The uterine cavity is examined only after vaginal irrigation, lest having previously escaped, it be infected by the septic vaginal discharges carried on the finger. The modified Bozeman canula is used. A hundred grain iodoform pencil is left in the uterus. This slowly disintegrates and is present in the discharges for two or three days. After this thorough disinfection, the fever, especially if due to putrid absorptions usually disappears. Otherwise vaginal irrigation is continued as before; and should new chills occur, or high temperature continue (above 103° or 104° F.), the uterus is again washed out and the iodoform pencil left in as before. The woman need not be disturbed during the manipulations. The vaginal irrigation is discharged in a bed-pan, then the canula is introduced within the uterus along the finger, as a guide. All air is previously expelled and the stream allowed to run during the introduction. Irrigation is continued until the stream returns clear—from one to three pints are necessary. After removing the canula the uterus is grasped and made to expel all fluid, and the perineum slightly retracted to insure its discharge from the vagina. Dr. Wilson sometimes irrigates through a speculum. No case of serious mercurial absorption has occurred. Salivation was induced in one case. No case of iodoform poisoning has been seen. Not infrequently after the intra-uterine douche, and quite commonly after the removal of more or less putrid material from the uterus, a chill and rise of temperature results, which soon subsides. This is partly due to nervous shock and partly to the temporarily increased absorption of poisonous material, caused by abrasions produced during the manipulations of the finger, curette or irrigat or.

In those unfortunate cases in which fever continues in spite of treatment, it becomes a question, after several days, whether irrigation is of further value. Fetor of the lochia is a constant indication, but it is not apt to be present after the removal of foreign matter and thorough utero-vaginal disinfection. In the presence of marked parametritis, without special indications to the contrary, the vagina alone should be douched.

On one case diphtheritic patches occurred on the fourchette. They were treated by the application of pure carbolic acid followed by iodoform.

Turpentine stupes, and at times poultices, are used in cases of metritis or peritonitis, with tenderness on pressure, and tympany.

Constitutional treatment, while considered in the majority of cases of secondary importance to local measures, is by no means neglected. Nor is it forgotten that in the cases in which marked invasion of the tissues and vessels by germs has taken place (before local antisepsis could cut off the supply), it is the only means of favoring a successful issue. The indications are to support the strength, combat hyperpyrexia, and meet special complications and symptoms. It is a problem of "the survival of the fittest" between the host and the invading germs.

Proper alimentation is of the highest importance, especially in protracted cases. Milk, given in quantities that can be assimilated, is largely depended upon. In irritable stomach lime water or whiskey is added. Beef tea, nutritious broths, and the various nitrogenous prepared foods are used as adjuvants, or where milk disagrees. Quinine in divided doses, not exceeding fifteen grains daily, is believed to conserve the strength. Whiskey is given as indicated. Most cases at all protracted, require it early, and can take it in large amounts. The first sound of the heart is the most reliable criterion by which to be guided in its administration. Brandy is at times substituted, and champagne is used where troublesome and otherwise uncontrollable nausea is present. The administration of spirits is considered of great value in combating septic fever.

Hyperpyrexia (approaching 104° F.), unless transient, is met by antipyrin (grs. xv to xx) repeated every hour or second hour, until the temperature falls below 102° F. The pulse is always watched during its

administration, and stimulants given if necessary. In two cases, which subsequently recovered, collapse occurred after the administration of two fifteen grain doses of antipyrin at intervals of an hour, the temperature falling to 97° F. Quinine in fractional doses is substituted when the temperature is below 102° F., being used principally for its tonic effect. The cold coil has been used in a few cases.

Opium is largely relied upon to allay restlessness, induce sleep, and relieve pain. Pain is very seldom complained of; tenderness on pressure is usually its greatest manifestation.

In the few cases in which peritonitis has been present, turpentine by the mouth and by enema has been used to relieve flatus. The question of opium *versus* saline purgatives is under consideration, but it is by no means considered advisible to prevent an occasional movement of the bowels.

For weak heart, while digitalis is used, more is expected from alcohol and alimentation. Ergot is believed to be of use in preventing septic absorption, not only by favoring an empty and contracted uterus when used *post-partum*, but also, perhaps, by its action on the muscular tissue of the utero-vaginal canal and absorbents, in the presence of septic material.

Other special complications and symptoms when present, are treated on general therapeutic principles.

Special Correspondence.

THE DAY BEFORE THE ASSOCIATION MEETS.

Cincinnati, May 7, 1888.

The day before the opening of the meeting of the American Medical Association is usually characterized by the gathering of a large portion of the members. Some of them come early so as to avoid the crowding and inconveniences of the first day, and some to meet their friends and talk over matters in which they feel especial concern, before the time for action arrives. In this respect the present occasion does not differ from its predecessors. The hotel corridors are thronged with active and earnest-looking men. Everywhere clusters of chairs are drawn up and men lean over toward each other as they talk and listen; and it is clear that the business of the Association is being discussed, and perhaps, arranged by those who make up the groups.

At this moment two questions are being actively discussed. The first is, who shall be the next President of the Association? The second is, where shall the next meeting be held? In regard to the presidency, three names are being canvassed: those of Dr. Moore, of Rochester, of Dr. Dawson, of Cincinnati, and of Dr. Matthews, of Louisville. Each name is supported by warm friends.

Dr. Moore and Dr. Dawson are urged for the office on the ground of their age and standing in the profession, and the fact that they are men whom the Association may appropriately honor with this distinction. The name of Dr. Matthews is being advocated chiefly on the ground that he is young, energetic, a good parliamentarian, and likely to be able to maintain order and discipline in the business meetings of the Association. Some recent experiences have convinced a number of the members of the Association that the body needs for the Presidency a man who adds to a high professional standing, familiarity with parliamentary rules and customs, and a quick and firm judgment. How far this opinion may go in the present canvass, it is now impossible to say; but there can be no doubt that it has much in its favor. The outlook now seems to be favorable to the election of Dr. Moore or Dr. Dawson.

At the meeting of the

American Association of Medical Editors,

held this evening, a permanent organization was effected by the adoption of a few articles of constitution. There was a large number of editors present, and an animated discussion took place in regard to the effect, upon medical journalism and the profession, of so-called "trade-journals." The general opinion was that they are of disadvantage to the members of the profession, as well as injurious to regular medical journals. This view was opposed by a gentleman—not a member of the Editors' Association—who was invited to speak on the subject. One of the editors expressed the opinion that there is no use in discussing this question, except as the discussion may lead to better work by the editors and publishers of medical journals; since the only practicable way to compete with the inducements offered by the manufacturing houses which issue journals of their own, is to offer the profession better journals at a reasonable price.

Among the men who are already here, there are many whom it would be a pleasure to name; conspicuous among them are Dr Garnett, of Washington, the President fo

this year; Dr. N. S. Davis, of Chicago; Dr. Garcelon, of Maine, and Dr. Henry H. Smith, of Philadelphia. These are the principle points which were impressed upon me during the day before the meeting of the Association.

On the first day of the meeting, May 8, a large number of delegates and members gathered in the Music Hall, and the meeting was formally called to order by Dr. Dawson, and opened with prayer by Rev. R. A. Gibson. After which, an

Address of Welcome

was delivered by Hon. Amor Smith, the Mayor of Cincinnati. In this address the mayor extended to the members of the Association a hearty welcome to the city. The address was excellent and sensibly brief, and contained amusing allusion to the time, twenty-five years ago, when the then mayor of Cincinnati thought it worth while to issue an order to the police, that for the time they should not be too strict with exhilarated midnight strollers, lest they should by mistake offer an affront to some rejoicing and belated member of the American Medical Association, which was then, as now, the guest of the city.

This order, Mayor Smith said, he would not now issue, lest he should seem to forget that since twenty-five years ago there were women who had entered the portals of the practice of medicine, and even of the American Medical Association, but he assured the members of the Association that everything in his power would be done to make their visit to Cincinnati both pleasant and enjoyable.

Dr. C. G. Comegys followed, on behalf of the Medical Profession of Cincinnati, in another address of welcome. In this, he gave an interesting sketch of the history of that part of the Ohio Valley in which Cincinnati is situated. He portrayed the settlement of this region, its vicissitudes of Indian wars and final deliverance from danger, and the development of its material and intellectual welfare.

Dr. Garnett's Presidential Address followed, and proved to be an able argument in favor of elevating the standard of medical education in this country, favoring a compulsory four years' graded course, a State examination for a license to practice, and cancelling the charters of schools which failed to show a class of at least fifty students for any period of five consecutive years. The address was received with marked manifestions of approval, and made an obvious impression upon the audience.

After some miscellaneous business had been transacted, the general meeting adjourned for the day.

In the afternoon the various sections met in the numerous and convenient rooms of the Music Hall, being well attended in spite of very changeable and threatening weather.

The reception of the Association by the medical profession of Cincinnati is most hearty, and the arrangements made for its accommodation, both scientific and social, are admirable. The members of the Association seem to be generally animated by a spirit of concord and fraternity.

The place of meeting next year will probably be either Philadelphia or Baltimore—most likely the former.

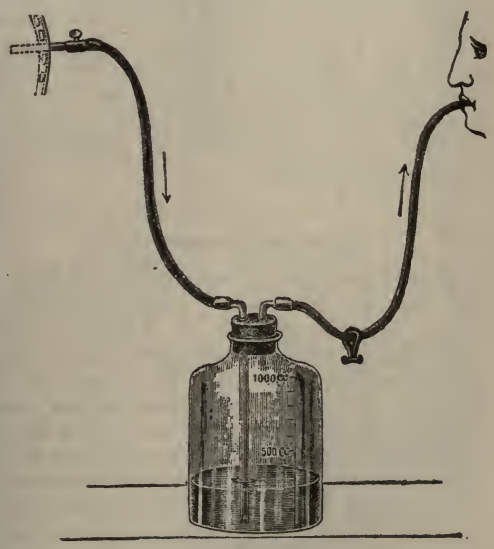
Yours truly. J. C. B.

PERISCOPE.

Apparatus for Removal of Pleuritic Effusion.

In the *Berliner klinische Wochenschrift*, March 26, 1888, Prof. Fürbringer, of Berlin, describes an ingenious and simple apparatus for the aspiration of serous effusions in the cavity of the pleura.

This apparatus, of which we give an illustration, is composed of a receiving-bottle



of about one quart capacity, with a rubber stopper, through which pass the ends of two glass tubes, bent at a right angle, and fitting hermetically. One of these tubes goes nearly to the bottom of the vessel; the other passes only through the stopper. The former is connected with a rubber tube, fitting over a canula three or four millimeters in

diameter, and supplied with a stop-cock; the latter is connected with another rubber tube supplied with a compression-stop. In using the apparatus, the end of the second tube is placed in the mouth of the operator and about three fluid ounces of a warm one to two per cent. solution of boric acid is sucked into the bottle through the other tube. The canula is then thrust with the aid of a trochar into the pleural cavity, the trochar withdrawn, the stop-cock closed, and the tube attached. The operator now sucks a little upon his tube and closes it; then the stop-cock in the canula is opened and the fluid begins to flow into the bottle. As soon as the effusion reaches the fluid in the bottle, the compression of the operator's tube is removed and the effusion will continue to pass into the vessels so long as there is any pressure upon it within the chest. When it ceases to flow spontaneously, its flow may be solicited by suction upon the operator's tube. In this way about a quart of fluid can be removed from the chest without any risk to the patient or inconvenience to the operator. If the quantity to be removed at one sitting is more than a quart, the canula can be closed, the bottle disconnected and emptied, new antiseptic fluid poured into it, the patient's tube re-connected to the canula and the subsequent steps of the preceding procedure repeated. The method described provides for the slow evacuation of a pleuritic effusion in the most gentle and satisfactory way. It has been used by Fürbringer in more than fifty cases without accident or inconvenience, and certainly deserves to be brought to the attention of American physicians.

Hydrastis Canadensis.

In a clinical and pharmaceutical study of the root by Givopiszew (*Thèse*, St. Petersburg, *Bulletin général de Thérap.*, Feb. 29, 1888), the writer presents the following results, which, so he states, are "based upon a large number of clinical observations and experiments upon animals:" 1. The aqueous extract, even in large quantities, did not produce toxic effects in warm-blooded animals. 2. It always caused a diminution of blood pressure without a previous augmentation. 3. It always induced contraction of the uterus and its appendages. Under the influence of an aqueous extract of hydrastis the most intense contractions took place in cases of advanced pregnancy, or soon after delivery; the contractions were weakest in the virgin uterus. 4. Large quantities of the extract may induce premature delivery in the second period of pregnancy. As clinical results, the author concludes: 1. Hydrastis is an excellent agent to combat uterine hemorrhages due to inflammation or false positions of the organ, as also against hemorrhages following the catamenial period, and in the case of too abundant menstrual losses. 2. Uterine contractions produced by hydrastis are less intense than those from ergot of rye. 3. Its use produces no untoward effect upon the organism. Even when taken for a prolonged period it causes no gastro-intestinal troubles, and often ameliorates dyspepsias which have previously existed.—*Amer. Journal of Pharmacy*, April, 1888.

Prevention of Syphilis.

The Paris correspondent of the *Medical Press and Circular*, February 15, 1888, states that M. Fournier has presented to the Academy of Medicine the report of the Committee appointed to inquire into the best means of preventing the spread of syphilis. The following are the principle articles: 1. The Academy calls the attention of the authorities to the development to which prostitution on the streets has grown, and demands that energetic means be taken to repress it. 2. The legion of wine-shops only assist clandestine prostitution and should be suppressed. 3. A strong and active surveillance should be exercised in the neighborhood of the colleges, where temptation is rife. 4. A girl proved to be contaminated should be sent to a special sanitary hospital, from which she should not be discharged without being furnished with a medical certificate; at the same time the rules of the hospital should have in nowise the stringent character of the present St. Lazare. 5. The registered women should be visited regularly once a week and once a month by a medical inspector. 6. Instead of increasing the number of beds in certain hospitals in which venereal diseases are treated, new special hospitals should be created outside the walls of Paris, to which free dispensaries should be attached. 7. Every student of three years' standing should have free access to all these institutions, and before presenting his thesis he must produce a certificate justifying a three months' *stage* in one of these services.

—An engine-fitter residing near Bolton, England, recently died from the effects of drinking an infusion of one ounce of colchicum seeds and a drachm each of iodide of potassium, slippery-elm, and guaiacum, the ingredients having been sold to him by a local herbalist.

Epithelioma of Penis and Scrotum; Complete Removal of External Genitals; No Recurrence at the end of Six Years.

F. A. Southam, assistant surgeon to the Manchester Royal Infirmary, reports the following case: John T., 55 years old, was admitted into the hospital in June, 1881, suffering from well-marked epitheliomatous ulceration of the penis. About twelve months previously the right testis had been removed for what had been regarded as "strumous disease," otherwise he had always enjoyed good health, and there was no history of syphilis. Amputation of the penis was performed, and the patient left the hospital at the end of the month, with the wound not quite healed. Between two and three months subsequently he returned with a recurrence of the ulceration, which presented all the appearances of epithelioma, in the stump of the penis and scrotum; the latter was somewhat extensively involved, a sinus leading down to the left testis, which from implication in the disease had become adherent to the scrotal tissues; the inguinal glands, though slightly enlarged and tender, appeared to be free from any secondary deposits.

In August, 1881, the stump of the penis, the remaining testis, and almost the whole of the scrotum were removed by two elliptical incisions carried wide of the disease, just sufficient integument being left on either side to meet in the middle line and cover over the extensive wound. The urethra and corpus spongiosum, which had been divided far back, were dissected out, turned downwards, and attached by sutures to the skin at the lower angle of the wound.

The patient made a good recovery, and left the hospital at the end of September. The wound had almost healed, and he was able to pass his urine very freely through the perineal opening. He attended as an outpatient during the next few months, and was then lost sight of. Nothing more was seen or heard of him until September, 1887, when, after an interval of six years since the operation, he came to the hospital to show that he was still alive and well. He stated that he had enjoyed good health since last seen, and had never experienced any difficulty with his urine. The perineal opening, which had not shown any tendency to contract, was large enough to admit a No. 10 catheter, and the urine was passed in a very good stream. He was quite free from any evidence of recurrence of the disease, either in the cicatrix or lymphatic glands in the groin.

The author remarks that the successful result in this case must be attributed to the fact that at the second operation the parts were removed wide of the disease, and that the lymphatic glands had not become the seat of any secondary deposits. Inasmuch as six years have now elapsed since its performance, the cure may be regarded as permanent and complete.—*Medical Chronicle*, March, 1888.

Case of Myxœdema.

At the meeting of the Medico-Chirurgical Society of Sheffield, January 19, Mr. W. Makeig Jones presented a case of myxœdema in a married woman, 50 years old, which had been gradually coming on for the last four or five years. About two years ago slowness of speech and general swelling of the skin was noticed. The symptoms were: Great anæmia, with limited rosy patches on both cheeks, centre of forehead and lips. Firm elastic swelling, not pitting on pressure, of the whole cutaneous surface, and also of the mucous membrane of mouth and throat. Commencing atrophy of both optic discs. Pupils sensitive to light. Characteristic thickening of skin over anterior triangle of neck. The thyroid gland, especially the left lobe, larger than in women of the same age. Systolic basic bruit. Exaggerated patellar reflex. Characteristic spade-like hands. Urine about one pint in twenty-four hours; pale, sp. gr. 1014—1020, full of phosphates, but not albuminous (it contained albumin eighteen months before). Temperature in mouth 96°. Pulse 48–60. General lethargy, slowness of speech, and stammering (she could, however, read fluently), slowness of movement, sensation and intellect. Unpleasant taste, but not smell.—*Medical Press and Circular*, February 8, 1888.

Laparotomy for Intestinal Obstruction Due to Gall-Stone.

We learn, says the *Lancet*, Feb. 11, 1888, that Mr. Charles Stonham has recently performed laparotomy in a case of intestinal obstruction, and found a gall-stone firmly impacted in the ileum, about twenty inches above the ileo-cæcal valve. The stone was removed by a longitudinal incision about one inch in length, and the wound closed with a double row of fine silk sutures. There was recent peritonitis of the gut above the stone, but none below. The patient, a woman, 66 years old, died fifteen hours later. Symptoms of obstruction had lasted forty-eight hours.

Experience in the Use of Cocaine.

Dr. Edmunds says that on applying cocaine subcutaneously for the production of local anæsthesia, it is not advisable to use a stronger solution than five per cent. In his earlier cases, in which this strength was used, constitutional symptoms were never seen; but when, owing to the anæsthesia in one case not being sufficient, he used stronger solutions, there occasionally occurred one or more of the following symptoms: pulse becoming very rapid, weak, and almost imperceptible; sense of faintness and feeling of distress in the region of the heart, blueness of lips, cold perspirations, restlessness, amounting almost to convulsive movements, and dilated pupils. Happily these symptoms never lasted very long; but as nothing of this sort was seen with a five per cent. solution, it seems better not to go beyond that strength.

Cocaine will entirely prevent the pain of the injection of tincture of iodine into the tunica vaginalis for the cure of hydrocele. In two cases a solution of five grains of cocaine in fifty minims of water, was injected through the canula after the fluid had been drawn off. When, after the lapse of five minutes, tincture of iodine was injected, there was no pain or feeling of faintness, nor were there any constitutional symptoms from the cocaine. The iodine and the iodide of potassium in the tincture of iodine react with the cocaine chemically, but these changes do not prevent the cure of the hydrocele. It is true that the injection of a saturated solution of carbolic acid in glycerine into a hydrocele sac does not cause pain; but this treatment is apt to fail.—*Lancet*, January 7, 1888.

Pulmonary Endarteritis.

At a meeting of the Pathological Society of London, February 21, 1888, Dr. G. F. Crooke showed specimens from a case of pulmonary endarteritis. The patient had complained of shortness of breath, pains in the left side and back, pain and fulness in the abdomen, and swelling of the legs. At the necropsy there was found stenosis of the mitral valve, probably congenital, hypertrophy of the left auricle, great hypertrophy of the right ventricle, and dilatation of the pulmonary artery. The smaller branches of the latter vessel showed great thickening of the intima, which was roughened and nodose, and was undergoing fatty changes. The smallest twigs showed marked obliterative endarteritis, and contained small adherent thrombi. There was no systemic atheroma. —*Lancet*, February 25, 1888.

Transudation and the Influence of the Blood-pressure upon the Behavior of Transudates.

Prof. H. Senator, of Berlin, concludes an article in *Virchow's Archiv*, Bd. cxi, Heft 2, Feb. 1888, with the following statements:

All transudates, without exception, contain albumin in solution, but in a smaller quantity than the blood-plasma. The quantity of albumin is smallest in normal transudates and in œdema of the skin. The albumins of the transudate are the same as those of the blood-plasma, namely, serum albumin, serum globulin and fibrinogen. Concerning their ratio to one another and to the quantity present in blood-plasma, little is known. The quantity of saline constituents in the transudate is pretty nearly the same as that in the blood-plasma, but varies slightly. Not rarely it surpasses that of the blood-plasma in the same person. All transudates contain such other non-colloid bodies as are in solution in the blood, bodies which never pass out in pure glandular secretions, such as biliary coloring matter and hæmoglobin. Substances not preformed in the blood are not found in any transudate, unless the latter has become decomposed. Tissues which produce transudates lack the specific powers of gland cells. Filtration experiments performed outside the living body are not decisive with regard to the influence of blood-pressure upon transudation. Rise in venous pressure effects increase of the quantity of the transudate and of its contained albumins, while the amount of its saline constituents is not materially changed. Rise in arterial pressure (*i. e.*, active hyperæmia) appears in the same manner to increase transudation. Nothing definite is known concerning the quantity of albumin in transudates occurring in simple arterial hyperæmia. Section of the sympathetic nerve seems to increase the quantity of albumin in the area of transudation. The quantity of saline constituents in the transudate is not materially changed in arterial hyperæmia.

—A plan for an enlargement of the Pennsylvania Hospital has been proposed, which will more than double the capacity of the hospital, and at the same time leave sufficient grounds around the building to make them attractive for convalescents. It is said that at the meeting next month a plan will be considered for a building fronting on Spruce street, with suitable annexes for the accommodation of physician, surgeons and nurses

THE

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CHARLES W. DULLES, M. D., EDITOR.

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AN IMPORTANT STEP IN VACCINATION.

In these days of antiseptic surgery, when it is believed that the most serious consequences may follow the introduction into the human system of germs which are constantly present in the air and on the surface of the body, it is a somewhat singular spectacle to see men who are full believers in the germ theory habitually doing a thing which according to this theory must be exceedingly dangerous. We refer to the practice of vaccination as it is ordinarily carried out. In this procedure a portion of the skin is scratched until the corium is reached, and then a portion of vaccine virus is thoroughly rubbed into it with the aid of sufficient moisture. It is the misfortune of physicians and patients that there is no practicable way of securing supplies of vaccine virus which will insure its entire freedom from the germs of erysipelas or some other disease; and, no matter how careful and conscientious the vaccinator may be, he may inoculate his patient with something very different from what he intended.

But there is another source of danger to the patient which does not depend upon the nature of the virus used, and which may have its share in producing the violent inflamed sores and profound constitutional disturbance which too often follows vaccination. This source of danger lies on the skin of the patient, in the shape of dead epithelium, which may have undergone some decomposition from the action of the perspiration, or of morbific organisms which have been deposited in it.

We believe this source of danger in vaccination has not received the attention it deserves, and that it would be profitable for some investigator to try to learn what proportion of bad arms are the consequence of the failure of physicians to render aseptic that portion of the skin of their patients which they select as the place for vaccination.

Meanwhile we would urge upon our readers the desirability of making it an invariable rule to thoroughly cleanse the site of vaccination with water and soap—and perhaps some antiseptic—and brisk rubbing; so that, if a bad arm follows, they may feel that they have not neglected so simple a step, which is suggested by common-sense and made almost imperative by the accepted tenets of general surgery. To vaccinate an unwashed arm ought, we believe, to be regarded as an error in practice.

TREATMENT OF PENETRATING WOUNDS OF THE ABDOMEN.

At a recent meeting of the Société de Chirurgie, of Paris, M. Reclus brought up for discussion the subject of the treatment of penetrating wounds of the abdomen, and more especially of pistol-shot wounds. From a careful study of the subject, and from the result of a number of experiments on dogs, he has come to the conclusion that a considerable proportion of cases in which the intestine is penetrated by a small body will recover spontaneously, and that the statistics of laparotomy do not offer anything better to the surgeon than is shown by his own studies of the result of expectant treatment combined with physical and physiological rest.

This view is diametrically opposed to that which is now current in the surgical world, and especially in this country. So it is interesting to note that it has not been admitted without question even in France. The Paris Society of Surgery has followed the subject up in a discussion which engaged the voices of the best surgeons of that city. The general conclusion was altogether favorable to what is recognized as the "American" idea: that laparotomy should be performed boldly in cases of penetrating wounds of the abdomen, where there is any reason to suspect that the bowel has been penetrated. According to Trélat, the chances are ninety-seven in a hundred that the bowel is penetrated when the abdominal wall is; and the views of Reclus are not borne out by general surgical experience.

It is well known that penetration of the stomach is not so likely to be followed by serious peritonitis; and this fact may be borne in mind in determining the propriety of laparotomy in individual cases; but in general we believe the whole surgical world accepts the view which is called the "American" view, and is not prepared to abandon it upon the ground of such evidence as M. Reclus has brought forward, no matter how fully both he and it are deserving of respect.

CURIOUS BACTERIO-THERAPY.

A few medical men have been carried away by that singular product of latter-day cerebration: "bacterio-therapy;" and a very few have actually attempted to put it into practice and have "set a thief to catch a thief" by administering the bacteria of one morbid condition to counteract the effects of the bacteria of another. This curious idea has not had much following, however, and appears now to have died the death it deserved.

But a communication of M. Frémont to the Société de Biologie of Paris, at its meeting on April 7, 1888, seems to look in the same direction. M. Frémont reports that an examination of the waters of Vichy has disclosed to him the presence of different varieties of micro-organisms in the waters of different springs, and he believes this fact accounts for the different medicinal properties of these waters, which he says are "almost" identical in chemical composition. It is hardly likely that M. Frémont has overlooked the fact that waters almost identical may produce different effects, for this reason alone; and the differences observed at Vichy must in his opinion be of a character which cannot be explained on a chemical basis. If this be the case, his appeal to the bacteria contained in it can be regarded only as an illustration of a sort of belief in bacterio-therapy. This is very curious; but it requires much further elucidation than M. Frémont has given it, before it can be accepted as of great scientific value. It would be interesting to have a full account of the character and numbers of the micro-organisms which he has found in Vichy water, and there ought to be little trouble in controlling his observations so as to determine whether there is something or nothing in his singular announcement.

CARE OF THE INSANE IN PENNSYLVANIA.

So long as insanity is one of the afflictions of the human race, one of the most interesting subjects of medical and humane thought must be how to provide for the helping and treatment of the unfortunate beings who suffer with it. The fifth Annual Report of the State Lunacy Commission of Pennsylvania shows that out of over nineteen thousand insane persons admitted to the five State Hospitals up to last year, more than seven thousand have been cured or improved sufficiently to be restored to their families. This admirable result indicates the great improvements which have been made of late in the care of the insane and in the treatment of mental diseases.

Part of the report referred to discusses the question whether or not State hospitals are better places for the care of the insane than county alms-houses. In regard to this matter the Commission is strongly of the opinion that State hospitals are much preferable to alms-houses. We have already, in the Reporter, April 14, 1888, expressed our own conviction that this is the case; and are sure that a knowledge of what still occurs in the

alms-houses of such enlightened States as New York and Pennsylvania would convince the most skeptical that they are not places for persons whose care and treatment demand so much skill and patience. We hope the time will soon come when no insane person will be confined in any establishment which is not especially designed for this purpose, and governed by men who have special fitness for such a work.

KUSTER'S OPERATION FOR HERNIA.

In the *Centralblatt für Chirurgie*, March 17, 1888, Prof. Küster calls attention anew to and advocates his method of operation for hernia. This method has been fully described a number of times. It consists in opening the sac in the usual way, restoring the bowel to the abdominal cavity, cutting off the sac, and stitching the edges carefully. After this the hernial opening is stitched, and the rest of the wound is closed by successive rows of continuous catgut suture, so that there is no space left for any accumulation of blood or serum between the cut surfaces. After the skin is sutured, the wound is painted with iodoform-collodion until no blood can come through the coating. After this no further dressing is applied.

Küster maintains that this method accomplishes all the objects of the usual antiseptic method, while it is much simpler than the latter. Its success depends largely upon the care with which the preliminary steps of the operation are carried out, and the strictly aseptic condition of the wound before it is sutured. Küster's opinion of its value is supported by the results he has obtained with it in thirty-three cases, in only two of which death followed the operation, and in neither of which was it attributable to the method.

Such a simple plan of treating the wound in herniotomy has much to recommend it on theoretical grounds, and is worthy of the attention of surgeons in this country, as well as in Europe.

VITA NUOVA.

The *Boston Journal of Health* continues its good work of exposing medical frauds by publishing a detailed description of an analysis of Harriet Hubbard Ayer's nostrum called "Vita Nuova." This is recommended—with abundant testimonials, of course—as a safe and sure cure for the alcohol habit. It is probably nothing but a native Port wine.

Our friends of the religious press may reflect upon this, when they sanction the insertion of advertisements containing the false statement that it is positively free from alcohol; and may ask themselves how they must appear to a profession which is not likely to judge such conduct too leniently when they lay themselves open to the accusation of taking money for promoting the schemes of designing and unprincipled adventurers.

Book Reviews.

[Any book reviewed in these columns may be obtained, upon receipt of price, from the office of the REPORTER.]

DISEASES OF THE SKIN: A PRACTICAL TREATISE FOR STUDENTS AND PRACTITIONERS. Second edition, thoroughly revised and enlarged. By JAMES NEVINS HYDE, A.M., M.D., Professor of Skin and Venereal Diseases, Rush Medical College, Chicago, etc. Philadelphia: Lea Brothers & Co. Price, cloth $4.50, sheep $5.50.

The author in his preface to the second (present) edition states that the volume has been thoroughly revised, and much new matter added; and this statement is verified by almost every page. In fact, so thoroughly has the revision been made that the result is practically a new work The numerous woodcuts, many of which are new, are, with few exceptions, good, and lend value to the book. The classification followed is that adopted by the American Dermatological Association. In a few respects, however, the author wheels from the regular track, as, for instance, in considering lichen-planus and lichen-ruber distinct diseases; in this he is in accord with Kaposi and Robinson. Dermatitis herpetiformis, erythrasma, myxœdema and other new and recently described affections receive attention. An exception is taken to the name of the first-mentioned, that of Dermatitis "*multiformis*" being considered more appropriate and descriptive. Reference is made also to "Prairie Itch," variously known as "Texas Mange," "Swamp Itch," etc. The author goes to the root of the matter, we think, when he states that his "personal experience has led to the conviction that these terms are loosely applied to a group of cutaneous symptoms of diverse origin;" the cases, as a rule, representing pruritus hiemalis and scabies. The operation of electrolysis for the removal of superfluous hairs is clearly and satisfactorily described. With the suggestion "to operate in succession on contiguous hairs when practicable" our experience is, however, not in accord, as under such circumstances conspicuous scarring almost invariably results. The use of cocaine inunctions or hypodermic injections, for the purpose of rendering the operation less painful, is very properly considered unnecessary and inadvisable. The subject of differential diagnosis is con-

sidered at length, and in the matter of treatment, also, it is fully up to date.

In fact, as already intimated, this second edition of Dr. Hyde's treatise is in reality a new work, and we are pleased to say reflects great credit upon its author. The student or practitioner will find it valuable either as a text-book or as a book of reference. The publisher's part has been equally well done.

Correspondence.

Correction.

Dr. P. F. van Hamel Roos, editor of the *Revue Internationale Scientifique et Populaire des Falsifications des Denrées Alimentaires*, thanks for the communication in your esteemed Journal (April 7, No. 14, p. 451), about his experiences with *nickel salts*. He begs to observe, the orthography of his name, as mentioned in your Journal, is not exact, and kindly requests to alter this in the next number of your Journal.

Amsterdam, April 21, 1888.

Correction.

In the article by Dr. Hiram Corson in the Reporter, May 5, on "Quinine, its Use and Abuse," on page 561, first column, thirteenth line from the bottom, read "ten grains, in doses of one or two grains every hour," instead of "ten grains every hour." The mistake is to be regretted especially because it makes Dr. Corson seem to advocate a practice which he distinctly states is both needless and costly. The firm of chemists referred to as the manufacturers of quinine in 1825, should have been Farr & Kunzi, instead of Farr & Kirnzic.

Notes and Comments.

Congenital Absence of the Vagina with Retention of Menstrual Fluid.

Drs. J. S. and A. S. McMurray, of Frankford, Ind., report a case of this kind in the *American Journal of Obstetrics*, March, 1888. The patient, who was 16 years old, came under their care August 2, 1888, with the following history as given by her mother: She is a twin, her mate having died in infancy. She had a mild attack of scarlatina at six years of age, but no sequelæ were recognized. She was of a cheerful disposition, healthy and vigorous, in mind and body, until about sixteen months prior to the above date, when she experienced the symptoms common to the advent of the menstrual function. But as there was no "show," the attempt was considered abortive. A few weeks subsequently the same symptoms supervened, somewhat aggravated. From this time on, these attacks recurred every four weeks with all the regularity of the well-established menstrual function; each time becoming more painful and lasting a longer time, until about six months before they saw her, when they became continuous and she had lost her health and vigor. During this time, the breasts were well developed, together with all the evidences of maturing womanhood. She was constantly under professional surveillance; her attendants gave her morphine and other anodynes for temporary relief, and emmenagogues without limit, but they availed nothing. Presuming hers to be a case of delayed menstruation, no examination of the genitals was made until this time, when she was taking from *three* to *five* grains of morphine a day, without obtaining even an hour's respite from pain. She grew worse and worse, and finally came under their care. She was then exceedingly emaciated and anemic, and her weight was about seventy-five pounds. Her face had the peculiar pinched look characteristic of long suffering and the morphine habit. Upon making an examination, they found the hypogastric region prominent, and easily outlined a well-defined globular mass, very similar to the pregnant uterus of five or six months. The pubes were well covered with hair, and the labia majora well developed, though upon being separated they revealed no introitus vaginæ, but only a shallow *cul-de-sac*, skirted with carunculæ myrtiformes. The perineum was distended; the anus pushed forward, "pouting," as in the second stage of labor. On introducing the finger into the rectum, a tumor was discovered pressing the perineum, and feeling to the touch like the œdematous scalp of a child's head approaching the vulva. It was thought that the uterus could be detected through the abdominal parietes, closely hugging the tumor above. This, however, was a deception as subsequent developments plainly showed. The ovaries were not discovered. The bladder was pushed upward and forward, and it was with difficulty that a catheter could be introduced.

Bearing in mind the history, linked with the facts present, they diagnosticated a typical case of congenital absence of the vagina, with retained menstrual fluid. She was put on tonic and aseptic treatment for several days, and on August 8 was operated on in order to establish a vaginal canal. The patient was placed in the lithotomy position, and the bladder being emptied through a catheter, a strong steel staff was passed through the urethra and held in position, steadying the vesico-rectal septum, and subsequently serving for a guide to protect that organ and the blad

der. The bottom of the interlabial *cul-de-sac* was raised with a tenaculum, and an elliptical section snipped away with scissors, parallel with the lips, one inch in length by half that width. Now, with two fingers of the right hand in the rectum, an exploratory trocar and canula was carefully passed in the direction of the normal vaginal line. When at a depth of two inches, resistance ceased, and the trocar was withdrawn, followed by a small issue of menstrual fluid, confirming the diagnosis. A long probe was passed through the canula which was then withdrawn, leaving the probe in its track, it serving as a guide to direct the advance of the forefinger of the left hand, with which the vaginal track was opened. Through this, there issued a flood of forty-eight ounces of dark, ropy fluid resembling treacle, so tenacious that it could be drawn out in threads a yard long. When the contents were well evacuated, the finger was again introduced, and the opening extended transversely both right and left until it was enlarged to the normal vaginal capacity. On examining the cavity, its walls were as firm as cartilage. Search was made for the uterus, but it was not recognized. The cavity was then thoroughly washed out with a hot solution of bichloride of mercury. A glass plug, as recommended by Sims, one inch in diameter, and three inches long, was then put into the canal. But it would not go as far as necessary, and on searching for the obstruction a stricture of the cavity was manifest, sufficiently close to prevent the introduction of the plug to its full depth. On closer examination, however, this proved to be the *cervix uteri resuming its natural form*, thus showing the uterus and a small portion of the vagina to have been one continuous cavity. The plug was retained in place by a T-bandage. She was put to bed and soon rallied from the anæsthetic. She at once began to complain of severe pains in the pelvis, which were true "after-pains," such as follow labor. She was given a full anodyne, but these pains persisted and did not disappear for nearly a week. Twice a day, for two weeks, the plug was removed, and the cavity thoroughly washed out with the bichloride solution; then once a day, for three weeks.

In a few days she began to build up, and rapidly convalesced. The glass dilator was worn at least twelve of each twenty-four hours, for three weeks after suspending personal surveillance of the case.

After about the tenth day all opiates were suspended; in fact no demands were present for their use, notwithstanding the liberal administration of morphine daily for over twelve months previous. A troublesome diarrhœa followed, attributable to the withdrawal of the drug, but as digestion improved and the system regained the function of assimilation, no further difficulty of this kind was experienced. Five weeks from the day of the operation, she walked into the authors' office, having come ten miles by rail the same morning. She still wears the plug at night, and will do so for a long time. The canal is as nearly natural as scar tissue, forming over a glass plug, can be, so soon after the operation.

Castration and the Development of the Genital Tract.

Dr. Kehrer, in 1879–80, made a series of experiments to ascertain the effect of castration on the development of the genitals in young animals; the results were published in his *Beiträge zur klinischen und experimentellen Geburtskunde und Gynäkologie*. He castrated rabbits between two and three months of age, and killed them one year later. He found that unilateral castration or spaying caused no arrest of development; on the other hand, when the operation was performed on both sides, the genitals and mammary glands remained stationary, never developing beyond the stage which they had attained when the essential organs were removed. Dr. Kehrer attempted to prove which theory was true—Pflüger's, according to which there existed in the uncastrated female a stimulus to growth through periodical irritation of the ovarian nerves set up by the ripening of follicles which goes on long before puberty; or, on the other hand, the theory that spaying caused a disturbance of the blood supply of the remaining genital organs, through the occlusion of the ovarian arteries. For this purpose he ligatured the ovary and ovarian artery in two series of experiments. He found that neither in unilateral nor in bilateral ligature of the tubes or extremities of the uterine cornua, with separation of the ovarian arteries, was the normal development of the genitals in any way affected. He concluded that the ovarian nerves, or some other and unknown influence in connection with the ovaries, played the most prominent part in stimulating the development of the genital tract.—*British Medical Journal*, March 10, 1888.

For Pityriasis Versicolor.

Ihle recommends the following:

℞ Resorcin.....gr. lxxv–c
Castor-oil.....f℥i¼
Alcohol.....f℥iv¾
Balsam of Peru.....gr. viiss.
M. ft. liniment.

Acetophenidine.

M. Gueroguiewsky has employed acetophenidine instead of antipyrin. It is a crystalline gray powder, insipid and inodorous, derived from phenol; it is soluble only in twenty parts of alcohol, and is eliminated by the urine, wherein it can be detected by the red coloration with perchloride of iron. In typhoid fever, tuberculosis, erysipelas and pneumonia, in doses of from two and a half to five grains, he found it to act as an antipyretic in from twenty to forty minutes after injection; the pulse and respiration diminishing in frequency, and sweating being induced. It also relieved pain, but doses of eight or ten grains are required to effect this end, as in migraine, cephalalgia and tabetic pains. It never upset the stomach, nor modified any of the other functions of the body; in this respect it seems to be superior to antipyrin.—*Lancet*, March 24, 1888.

Effects of Moderate Drinking on the Heart and Circulation.

Dr. George Harley sums up the effects upon the heart and circulation which he believes follow the moderate use of alcohol, in the following propositions: 1. Alcohol, when indulged in, even well within the limits of intemperance, has a most prejudicial effect on heart disease. 2. Sudden spurts of muscular exertion act most deleteriously on all forms of organic cardiac affections. 3. Mental excitement is a cause of rupture of atheromatous blood-vessels. 4. A mere extra distension of a stomach by wind may suffice to fatally arrest a diseased heart's action. The knowledge of these facts, he says, has for some years past led him to make it an invariable rule to impress upon all patients laboring under diseases of the circulatory system, who desire to minimize the effects of their complaints and ward off as long as possible the inevitable fatal termination, to pay strict attention to what he calls the following three golden rules: (1) Take exercise, without fatigue; (2) Nutrition, without stimulation; and (3) Amusement, without excitement.—*Lancet*, March 24, 1888.

Death from a Druggist's Blunder.

The N. Y. *Evening Post*, April 11, 1888, says that considerable excitement has been caused at Bellows Falls, Vermont, by the result of the examination of the remainder of the medicine taken by one Wm. Riley, April 5, from the effects of which he died. He called at a drug store for ten grains of quinine, which he mixed with whiskey, and then swallowed two thirds of the mixture. Examination proves that the supposed quinine was morphine. The authorities have not as yet taken any action.

Proposed Plan of Supplying Infants with Pure Milk.

The Paris correspondent of the *N. Y. Medical Journal*, April 7, 1888, says:

The *Société de Médecine pratique*, while recognizing that mother's milk is the best for children, cannot, however, overlook the fact that an immense majority of babies are now-a-days brought up on cows' milk, and, as they are of the poorer classes, who cannot pay enough to secure pure milk, it begs the city government to take the matter in hand, and to construct and maintain model dairies, as is the practice in the towns of Stuttgart and Hamburg. A call is made upon the patriotism of the French Government to adopt this plan of securing pure milk for the babies, whose numbers are being diminished by thousands every year, and the hope is expressed that the city will undertake the important work of supplying pure milk at a low price for all the poor babies of Paris. It is not a bad idea if it could be carried out without making a job of it, as would be the result in some countries if it was a government affair.

Method of Identifying Criminals.

The anthropometrical method of identifying criminals, originating in Paris, has been adopted in the prison at Joliet, Ill. In addition to the photograph of the prisoner, accurate measurements of his height, the length and width of his head, the length of the left middle and little finger, of the foot, the forearm, the ear, the stretch of the arms, description of scars, color of the eyes, and so on, are recorded; and it is thus possible to identify prisoners assuming false names with far greater ease than was before possible. It is asserted, that, in the two years that the system has been in operation in Paris, 826 habitual criminals arrested under assumed names have been identified. Besides the practical utility of the system, it amasses very valuable statistical data contributing towards the natural history of the criminal classes.—*Science*, March 30, 1888.

New Resident Physicians.

Drs. James H. MacMillan, W. T. Sharpless, M. G. Miller and C. W. Sharples, who passed the requisite examination for Resident Physicians of the Philadelphia Hospital, entered upon their duties May 2. There are at present 1,629 patients in the hospital.

Vaccination in China.

Small-pox is epidemic in Hong-Kong, and during the week ending January 28, eighty-eight persons died from this disease. A law has been passed by the Governor and Council making the practice of infant vaccination compulsory in the colony, the Chinese member of the Council stating that his countrymen were strongly in favor of it. A local newspaper sent us by a correspondent enables us to learn something of Chinese thought upon the subject, the article referred to being based upon a pamphlet written by a Chinaman named Chang. The object of vaccination in China, it seems, is to purify the child of the fœtal virus which every child possesses, and which is generated by the passions which gave him birth, and this virus is the attractive cause of small-pox and other ailments. The Chinese anti-vaccinationist evidently accepts this theory, but comments on the absurdity of attempting to let this virus out in two or three pustules. Mr. Chang, however, has a ready reply: The fœtal virus congregates about the Gate of Life and the Three Passages. He does not say where these are, but on either arm, between the shoulder and the elbow, are two depressions, the "eddy of purity and cold," and the "lesser estuary," which two communicate by means of veins directly with the Gate of Life. By introducing vaccine, therefore, in the upper part of the arm, it is conveyed by the flowing of the blood along the vein to its goal. For the reason that "blood must be warm before it can flow," (*vide* Chinese text-books) "cold" food must not be given the patient, or rather, to use our popular expression, food which is credited with being "cooling."—*Lancet*, March 24, 1888.

Masculine Attire for Women.

A petition of a somewhat eccentric nature has just been addressed to the Chamber of Deputies by a young French lady. It is nothing less than a demand on behalf of women generally to be allowed to don male attire. The fair petitioner claims that woman will be better at ease and enjoy more freedom in her motions if dressed as a man. She instances the recent calamities in theatres in support of her statement that the loss of life would not have been so appalling had not a great part of the audience worn petticoats. The custom of the fairer portion of mankind wearing male attire is said to have originated in England. In fact, a female society, existing in England, has boldly raised the standard of revolt. At clubs and meetings its members appear in male costume, which, by the way, they wear with more conviction and pluck than elegance. The statutes of the society call upon its members to lose no opportunity of publicly manifesting their rooted aversion to gowns, skirts and petticoats. "This is the only way," said the president of the society," lately, "we shall succeed in overcoming routine, and ridding ourselves of the ugly, heavy, uncomfortable and costly dress we have been condemned to wear for centuries." To this question, however, there is another side, apart from the comical aspect, and were coquetry not in the van to vindicate its rights, with the majority of French women, who would not fail to stand by it, we might predict to the "young French citizeness" and reformer of dress, that routine itself will constitute the necessary damper.

The Use of Acidified Corrosive Sublimate as an Antiseptic.

Some very interesting experiments of great practical importance have recently been made by E. Laplace (*Deutsche medicinische Wochenschrift*, 1887, No. 40, p. 866-7) in the Hygienic Institute of Berlin, on the antiseptic action of corrosive sublimate when used in acid solution. It has long been known that the efficiency of bichloride of mercury is much reduced when it is brought in contact with albuminous substances, owing to the formation of insoluble compounds; thus when applied to animal tissues, the mercury becomes mordanted, as it were, on the surfaces with which it first comes in contact, the sphere of its activity being thus greatly diminished. Laplace finds that five cubic centimetres of blood serum is sufficient to precipitate the mercury from five cubic centimetres of the bichloride solution (1–1000). The formation of this precipitate of albuminate of mercury can be prevented by adding dilute hydrochloric acid (5–1000) to the bichloride solution (1–1000), whereby the antiseptic power of the latter is greatly increased. Similar results were obtained by the addition of tartaric acid. The solution recommended for use consists of 1 part sublimate, 5 parts tartaric acid, and 1000 parts of distilled water. The bandages, gauze, etc., on the other hand, are soaked for two hours in a stronger solution; namely, sublimate 5 parts, tartaric acid 20 parts, distilled water 1000 parts, after which they are wrung out and dried.—*British Medical Journal*, Jan. 21, 1888.

Mastoid Periostitis from Injury to the Auricle.

Dr. Thomas Barr, surgeon to the Glasgow Ear Hospital, reports, among other traumatic affections of the ear, a case of injury to the auricle, exciting mastoid periostitis. The patient was a boy, who stated that three weeks previously a man caught hold of his ears, lifted him off the ground, and suspended him in this way for a few seconds. The boy alleged that there was no pain at the time. A few days afterwards, however, pain and swelling commenced around the auricle, which was treated by hot fomentations. On admission he was suffering from intense pain over the right mastoid region and side of the head. The pain was so severe, that he had not slept for two nights. The auricle was jutting from the side of the head, and the swelling and the œdema extended from the mastoid region very markedly over the temple, right side of forehead, lower eyelid, and front of ear. The swelling over the forehead pitted deeply under pressure with the tips of the fingers. There was, however, very little redness anywhere. The internal ear was normal. There had been no rigors, but the temperature was 101°. Although there was no evidence of the existence of pus, it was resolved to cut into the tissues forming the seat of greatest pain. Chloroform was used, and an incision two inches in length was made through the soft tissues and periosteum, to the bone. Only a drop or two of pus escaped, apparently from beneath the periosteum. The effects of this incision were most satisfactory. All the unpleasant symptoms rapidly abated, and in the course of a fortnight the boy was at work again, and the incision wound almost healed.—*Popular Science News*, March, 1888.

New Eye and Ear Hospital.

Articles of incorporation have been secured for the New Amsterdam Eye and Ear Hospital of New York. Dr. Pooley, who was for fifteen years the first assistant surgeon of the New York Ophthalmic and Aural Institute founded by Dr. Knapp, is the executive surgeon in charge of the new hospital. It is expected to open in a short time. The hospital is to be supported entirely by voluntary contributions.—*Evening Post*, May 4, 1888.

Western Pennsylvania Medical College.

The annual commencement of the Western Pennsylvania Medical College was held on March 24, and thirty-four men were graduated as physicians. A collation was served to the graduating class in the evening by the Faculty and alumni. This commencement closes the second successful year of this college.

University of Pennsylvania.

The one hundred and fourteenth annual commencement of the Department of Medicine and Dentistry of the University of Pennsylvania took place May 2, at the Academy of Music. Prayer was offered by Bishop Whitaker, after which Provost Pepper conferred the degree of Doctor of Medicine on 114 graduates, and the degree of Doctor of Dentistry on 56 graduates. This was followed by the valedictory address, delivered by Dr. John Ashhurst, Jr., Professor of Clinical Surgery. A portrait of Professor R. A. F. Penrose was presented to the Board of Trustees by Dr. N. H. Hall, on behalf of the graduating class. Dr. James H. Hutchinson responded for the trustees.

The following prizes were awarded:

The Alumni Prize of $50, to the graduate who attains the highest general average in examination, to William T. Sharpless, of West Chester, Pa.

Medical News Prize of $100, for the best thesis, divided between John L. Hatch, of Rochester, N. Y., and Seneca Egbert, of Franklin, Pa.; distinguished mention to Adolfo Ferrer Leon, of Tabasco, Mexico.

Morbid Anatomy Prize of a Zentmayer's histological microscope, for best thesis on any subject connected with pathology, to Casper Wistar Sharples, of Eugene City, Oregon.

Demonstrators' Prize, $30, by Dr. John B. Deaver, Demonstrator of Anatomy, for best record of anomalies found in the dissecting room, to John T. Green, of Easton, Pa.

The following prizes were awarded by Dr. J. William White, Demonstrator of Surgery:

First Year Prizes—Proficiency in bandaging: First, Edward Strayer, a copy of "Agnew's Surgery;" second, Wesley A. Anders, a copy of "Ashhurst's Surgery." Honorable mention was made of S. P. Eagleton, John P. Frishmuth, Edward Kerr, Thomas P. Tyson, J. D. Webster.

Third Year Prizes — For proficiency in bandaging and in operatic surgery: First, "Agnew's Surgery," to Frank P. Lenahan; second, White's pocket case of surgical instruments, to Charles Walter. Honorable mention of John T. Green, Frank N. Yeager, W. T. Sharpless, A. Livingston Stavely, Shepard Voorhees, Robert G. Le Conte, C. W. Sharples, Frank H. Harding.

NEWS.

—Dr. Charles McBurney has been appointed visiting surgeon to Roosevelt Hospital, New York, in place of Dr. Sands, who has resigned.

—It is announced that Dr. Frank Woodbury has retired from the management of the *Philadelphia Medical Times*, which will hereafter be conducted by Dr. W. F. Waugh.

—Dr. Charles E. Simmons has made a claim upon the Tilden estate of $143,350 for medical attendance upon the late Samuel J. Tilden, from 1879 up to the time of his death, a period covering nearly eight years.

—The Cincinnati *Lancet-Clinic* is publishing a daily edition during the session of the American Medical Association, in Cincinnati.

—Dr. Howard A. Kelly and Dr. Barton Cooke Hirst have been elected Associate Professors of Obstetrics in the Medical Department of the University of Pennsylvania. They will jointly occupy the chair made vacant by Prof. Penrose's resignation.

—The State Convention of Homœopathists in Kansas City passed a resolution requesting Governor Moorehouse to remove from the State Board of Health Mr. George M. Cox, of Springfield, Mo., who achieved some notoriety some time ago by attacking a woman in a hack and throwing vitriol in her face.

—All the druggists of Davenport, Iowa, have united in giving formal notice that after April 30, they will not sell or dispense any alcoholic liquor of any kind for any purpose whatever. They have been advised that the conditions of the prohibitory law passed by the last General Assembly are such that business cannot be done without violating it. There are, however, some two hundred saloons still openly doing business in Davenport, besides some wholesale liquor houses.

—The Medico-Legal Society of New York has decided to hold an International Congress of Medical Jurisprudence, at which representatives from all countries will be invited to attend and contribute papers. The Congress will hold a session of four days some time next year. Members of the Medico-Legal Society will entertain as guests all foreign visitors, and arrangements will be made for reduced rates of ocean and railway travel for those who attend from a distance.

The Chairman of the Sub-Committee, Mr. Moritz Ellinger, is the Corresponding Secretary of the Medico-Legal Society.

HUMOR.

Mrs. Society—"What a lovely baby that is we just passed." Mrs. Fashion—"Yes; it is mine." "Indeed!" "Oh, I'm sure of it; I recognized the nurse."—*Observer.*

Surgeon's wife—"How is the walking out to-day, my dear?" Physician—"Beautiful, beautiful; the pavements are full of banana skins!" "Ha! ha! beautiful," echoes the reporter on the hunt for items.

"Ma, de fiziology say yer dat de human body am imposed of free-fourth watah!" "Waal, yo' bettah mosey off to school, an' git outen dat hot sun, ur fust ting yo' know yo' be vaporatin'."—*Harper's Bazar.*

Miss Clara—"Oh, Ethel, I had my ears pierced to-day!" Miss Ethel—"Weren't you dreadfully frightened?" Miss Clara—"A little at first, but I kept saying 'solitaire,' 'solitaire,' 'solitaire,' to myself, and before I knew it it was all over."

"Only think," exclaimed Fenderson, reading of the devastations of the locusts at the West, "last summer they ate up every green thing." "What a fortunate escape!" said Fogg; "you were thinking of going out that way last spring, I believe."

Judge to a prisoner—"Are you married?" Prisoner—"Yes." Judge—"To whom?" Prisoner—"To a woman." Judge—"Of course; that goes without saying." Prisoner—"Oh, no, your honor; for there's my sister; she is married to a man!"

Curious Request for Medical Services.—A subscriber to the Reporter sends us the following request from a young colored man who wished to have his chest examined:

"I acquire your physitiancy to examine my personal, and oblige.

Respectfully, * * * *"

An impertinent lawyer was arguing a case involving manorial law before Lord Mansfield. Said he, "My Lord, I happen to know a good deal about this subject, for I have two little manors myself." "Yes," interposed his lordship, "I have frequently noticed that."—*American Druggist.*

Studying the Weather.—"Mamma," said a pretty young thing in her new spring street costume, "have you the morning paper?" "No, Clara; your papa took it down town with him. There is yesterday's morning paper on the table." "Oh, that will do just as well. I only want to look at the weather probabilities."—*Puck.*

OBITUARY.

ISAAC PURSELL, M.D.

Dr. Isaac Pursell was born near Easton, Pa., September 19, 1823. When a child his parents moved to Phillipsburg, N. J., or rather to a farm near there. He studied medicine with Dr. Wilson, of Bethlehem, Pa., and was graduated from the University of Pennsylvania. He first began the practice of medicine at Rushtown, Pa., near Danville, where he married Miss Delia, daughter of Colonel Scott. Shortly after he removed to Berrysburg, Pa., thence to Shamokin, in 1858, and in 1861 to Danville, where he remained until the date of his death. He became a member of the Pennsylvania State Medical Society in 1874, and later of the American Medical Association, to both of which associations he was warmly attached, and the annual gatherings of which, until within two or three years of his death, he greatly delighted to attend.

The writer of this sketch became a student in Dr. Pursell's office, at Berrysburg, and has been in close correspondence with him ever since. He was a careful and conscientious practitioner of medicine, one who carried good cheer and sunshine wherever he went, and his professional visits were a benefit to his patients. He enjoyed a large general practice, which he kept up until a short time before his death. He was the soul of honor professionally, was modest and unassuming in his manners, never paraded his professional qualifications, and heartily detested shams of all kinds, whether in medicine, politics or religion. He was a consistent Christian, and an earnest and pronounced advocate of temperance. He died at his home in Danville, March 27, 1888, of cerebral apoplexy, after a few hours illness. J. F. K.

J. FORD PRIOLEAU, M.D.

Dr. J. Ford Prioleau, of Charleston, S. C., died at Beaufort, April 11, at the age of 62 years. He was graduated from the Medical College of the State of South Carolina in 1847, and in 1871 he became professor of obstetrics in the same institution. In 1881 he was made Dean of the college, and held that position until the time of his death.

Official List of Changes in the Stations and Duties of Officers serving in the Medical Department, U. S. Army, from April 22, 1888, to April 28, 1888:

Lieutenant-Colonel Jos. C. Bailey, Assistant Medical Purveyor, granted leave of absence for twenty days on surgeon's certificate of disability, with permission to apply for an extension. S. O. 92, A. G. O., April 21, 1888.

Lieutenant Colonel Jos. C. Bailey, Assistant Medical Purveyor, will transfer the public funds, for which he is responsible, and the charge of the medical purveying department in New York City, temporarily, to Capt. Henry Johnson, Medical Storekeeper. S. O. 92, A. G. O., April 21, 1888.

Par. 13, S. O. 89, A. G. O., April 18, is revoked by par. 1. S. O. 93, A. G. O., April 23, and Major Geo. M. Sternberg, Surgeon, U. S. Army, is directed to proceed to the Island of Cuba for the purpose named in the letter of the President addressed to the Secretary of War on the 17th inst.; upon the completion of this duty will return to his proper station, and submit his report to the President on or before June 25, 1888.

Major R. S. Vickery, Surgeon, granted leave of absence for four months, with permission to apply for an extension of two months, and to go beyond sea. S. O. 95, A. G. O., April 25, 1888.

By direction of the President, Surgeon Remus C. Persons, U. S. Navy, is assigned, temporarily, to the charge of the Army and Navy General Hospital, Hot Springs, Ark., during the absence, on leave of Major R. S. Vickery, Surgeon U. S. Army, Surgeon in charge. S. O. 96, A. G. O., April 26, 1888.

First Lieutenant Leonard Wood, Assistant Surgeon, granted one month's leave of absence, with permission to apply for an extension of two months. S. O. 41, Dept. Ariz., April 18, 1888.

First Lieutenant L. G. Anderson, Assistant Surgeon, granted one month's leave of absence from June 1, 1888. Resignation accepted by the President, to take effect July 1, 1888. S. O. 92, A. G. O., April 21, 1888.

Official List of Changes in the Stations and Duties of Officers serving in the Medical Department, U. S. Army, from April 29, 1888 to May 5, 1888:

Capt. A. A. De Loffre, Assistant Surgeon, granted leave of absence for six months on surgeon's certificate of disability, with permission to go beyond sea. S. O. 99, A. G. O., April 30, 1888.

First Lieutenant Guy L. Edie, Assistant Surgeon, now under orders to report for duty to the commanding officer, Fort Douglas, U. T.; will accompany the 8th Cavalry from Dept. of Texas to Dept. Dakota, and upon completion of this duty will proceed to Fort Douglas. S. O. 99, A. G. O., April 30, 1888.

First Lieutenant Wm. D. McCaw, Assistant Surgeon, relieved from duty at Fort Leavenworth, Kan., and ordered for duty at Fort Crawford, Col. S. O. 48, Dept. Missouri, May 1, 1888.

First Lieutenant Ogden Rafferty, Assistant Surgeon (recently appointed), ordered for duty at Fort Clark, Tex.

Capt. John V. Lauderdale, Assistant Surgeon, ordered from Fort Clark, Tex., to Fort Davis, Tex. S. O. 98, A. G. O., April 28, 1888.

Changes in the Medical Corps of the Navy for the week ending May 5, 1888:

Medical Director W. T. Hord and Surgeon T. Woolverton, ordered as delegates to represent the Medical Department of the Navy at the meeting of the American Medical Association, May 8, at Cincinnati, Ohio.

Surgeon Geo. P. Bradley, ordered to Navy Yard, Brooklyn, N. Y., without delay.

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Clinical Lecture.

CRETINISM: CASES PRESENTING TREMOR AS A SYMPTOM WITH THE EXHIBITION OF A PATIENT SHOWING SYMPTOMS OF PARA-MYOCLONUS MULTIPLEX.

BY JAMES HENDRIE LLOYD, M.D.,

PHYSICIAN TO THE PHILADELPHIA HOSPITAL AND INSTRUCTOR IN ELECTRO-THERAPEUTICS IN THE UNIVERSITY OF PENNSYLVANIA.

Reported by William H. Morrison, M.D.

Gentlemen: In the previous lectures which I have had the pleasure of delivering before you, I have dealt entirely with the subject of insanity, which is a failure or perversion of mental power or faculties, the result of change or disease coming on in later life, that is, either in adolescence or adult life. There is another great division of mental impairment which is termed idiocy, and of which we have very marked specimens in this hospital. Idiocy may be defined to be a failure, or more properly a lack of development, of mental faculties dating from a period before birth or previous to the period of normal development of the child's intellectual faculties. All idiots are not necessarily congenital idiots, although the affection must date from early childhood before the brain has become developed.

It is not my intention to attempt to-day to cover such an extensive subject as idiocy. There are many forms, and they have been classified by Dr. Ireland in ten divisions. He speaks of (1) the genesic idiot, that is one born so; (2) of the eclampsic or (3) epileptic form, that is those which exhibit epileptic seizures; (4) the paralytic; (5) traumatic or (6) inflammatory, or those in which the idiocy depends upon some accident either after birth or at the period of birth. It is important that the general practitioner should remember that in a certain proportion of cases the idiocy is due to accidents during labor, either by prolonged labor, by some resistance in the maternal soft parts, some defect in the pelvic canal, or by the use of the obstetric forceps. I have no doubt that some cases of idiocy are due to the use of the forceps, sometimes unavoidably so. These cases of paralytic or traumatic idiocy are often accompanied, as the name indicates, by paralytic phenomena. There is often hemiplegia, and not infrequently certain abnormalities in the shape of the head, such as flattening of the forehead or crushing in of the side of the head. I have seen several such instances. We have next, according to Dr. Ireland's classification, the (7) micro-cephalic and the (8) hydro-cephalic types of idiocy. The first form in which the head is smaller than normal is always congenital. Any case in which the circumference is less than eighteen inches is regarded as micro-cephalic. Some, in fact, go far below this, even as low as thirteen inches. The appearance of these cases is very characteristic. You have all seen instances of the hydro-cephalic idiot, although all patients with hydocephalus are not necessarily idiots. We next have (9) idiots by deprivation of the senses; that is, those born without the ordinary avenues of sensation. One of the most interesting examples of this group was Laura Bridgeman, whose case was described by Dickens. She was deaf, dumb and blind. She was, however, carefully educated by her instructor. I think that she was, properly speaking, not an idiot. We have then (10) the last division. These are the cretins and cretinoid idiots, and it is to this class that I wish to call particular attention.

Cretinism.

It so happens that we have in this hospital one of the best illustrations of the cretinoid idiot which it is possible to find on this continent, where pure cretinism is not endemic, and where we have only occasional sporadic cases. This man, for so he is, although no taller than a child of four or five years of age, is 29 years old, and has been an inmate of this hospital for many years. With reference to cretinism, it presents certain very distinct and special characteristics which are not found in other forms of idiocy. As you all know there is a form of this affection known as endemic cretinism, found especially in certain mountainous regions, as the Alps and Pyrenees in Europe, and the Cordilleras mountains in this hemisphere. We have practically nothing of it in the United States. Cretins as found in the Alpine villages are, in their worst forms, not unlike the individual before us. The cretin is stunted in stature, he is very deficient in intellect, he usually has a much enlarged thyroid gland, which is not the case in this instance, and he has a peculiar and typical physiognomy which we see to a certain extent in this case. The bridge of the nose is much sunken in and the nostrils flattened out; the eyes are widely separated, with an almost translucent appearance of the structures about the eyes. The lips are thick and large, the mouth constantly open, the hypertrophied tongue protrudes. There is also a tendency to slobber. Cretins also have a peculiarly white or rather a waxy appearance of the skin. The skin is apt to be hypertrophied and scaly. The hands are large, flabby and spade-like. The abdomen is protuding. The sexual apparatus is often undeveloped. The limbs are very short and covered with poorly-developed muscles. There are all degrees of endemic cretinism, varying from a severe form up to one in which there are very slight evidences of the dyscrasia.

There are several interesting questions connected with this subject, especially with reference to goitre and that peculiar condition known as myxœdema. This is a very obscure subject on which I am able to throw very little light. I can only indicate what is known about it. These cases of endemic cretinism as seen in mountainous regions are usually accompanied with enlargement of the thyroid gland. We have also cases of sporadic cretinism, of which this case is an example, as he was born in Philadelphia, in which the enlargement of the thyroid gland is usually absent. There is in fact in most of the sporadic cases, no evidence of the presence of a thyroid gland. I suppose that in the present instance not a vestige of the thyroid gland would be found on dissection. There are, however, certain accumulations of tissue over the clavicles which form distinct masses and are very characteristic of sporadic cretinism. The condition known as as mxyœdema is allied to cretinism. It is a hypertrophy of the subcutaneous connective tissue in the meshes of which is a product known as mucin. There has been observed a certain relation between this condition of myxœdema and enlargement of the thyroid gland. They, as it were, counter-balance one another. Where there is enlargement of the thyroid gland, it seems as though the whole force of the dyscrasia was spent in this way, whereas in cases in which there is not this hypertrophy, the condition myxœdema is present. This is of much practical importance especially to surgeons. It was discovered sometime ago by Horsley, of London, that if the thyroid glands of monkeys are removed, a condition of myxœdema is likely to appear, and the animals also present the characteristic cretinoid physiognomy. What the relation between these two conditions is, has not been thoroughly elucidated; I can only state the facts. As I have said this is of importance to the surgeon, who is sometimes called upon to extirpate the thyroid gland. I do not know whether or not the destruction of the gland by galvanic puncture would tend to induce this condition of myxœdema. It would, however, be a great misfortune for the patient to exchange her goitre for a condition of myxœdematous degeneration.

Very little is known with reference to the true pathology of cretinism. There are, however, one or two views brought forward by those who have especially investigated the subject, and to these I wish briefly to call attention. It is found on dissection in all cases of cretinism, that they present to a marked degree what is known as basilar synostosis, that is to say, early ossification of the cartilage, which normally exists in early life between the body of the sphenoid bone and the basilar process of the occipital bone.

I shall next call attention to one or two features presented by this case. The enlargements over the clavicles are very characteristic. You note the coarse hair, the widely separated eyes, the large increase of tissue about the eyes, the thick lips and constantly protruding tongue. The man's eyesight is very poor; his intelligence is very low, but he probably knows more than we would give him credit for from his appearance. He shows often to those familiar with him that

he does take notice and does remember. You observe the protruding abdomen, and the small, crooked legs. He can walk a little, but he does not do it unless compelled to. His sexual organs are those of a boy three or four years old. Another feature is his utterly apathetic condition, the purely vegetative life which he leads. As you see him here, so he sits all day long. He interests himself in nothing, and requires nothing to amuse him. He has very few accomplishments; the only two which I recall are that he can swear like a tramp and kiss his hand to the ladies. His range of words is limited, but he seems to understand most that is said to him.

One more word with reference to the anatomical condition in this affection. It is almost invariably, if not invariably, found that there is this premature synostosis or alteration in the cartilage between the body of the sphenoid and the basilar process of the occipital bone, and it has been supposed that this is the cause of this peculiar state. Whether or not this is the case, we cannot be positive. It was Virchow, I believe, who originally demonstrated the existence of this anatomical condition. It is conjoined with premature ossification of the epiphyses of the long bones, helping to produce the dwarfed condition of the limbs, which is seen in cretinism.

Cases Presenting Tremor as a Symptom with the Exhibition of a Patient Showing Symptoms of Paramyoclonus Multiplex.

I shall now call your attention to certain forms of tremor and myoclonic disorder—a very wide and interesting subject. The whole subject of tremor, ataxia, irregular spasm, and local convulsion unaccompanied with loss of consciousness, presents numerous difficulties to clinical pathological study. We have succeeded in differentiating certain varieties of these into well-marked forms of disease. For instance we have the pure and simple chorea, the chorea of childhood, the disease known as Sydenham's chorea, which can usually be diagnosed without difficulty. We have, however, other forms, approaching the choreic form which are not so easily diagnosticated, and the pathological conditions underlying which present many difficulties and mysteries. Besides chorea, there are some other forms of motor disorder which are not difficult to recognize. Among these we have Parkinson's disease or paralysis agitans. Then we have tremor depending upon change in the nervous structures, which is termed disseminated sclerosis or sclerosis in plaques.

The three patients now before you represent to a certain extent these three forms of motor disorder. The first case can be dismissed with a very few words. This woman is suffering with paralysis agitans, an affection which was first described by Parkinson in 1817. I want you to note that the arms and limbs, and the forearms more especially, are in a condition of constant tremor, which presents certain characteristics not seen in any other form of tremulous disorder. In the first place the tremor is constant during the absence of voluntary motion. The character of the tremor also is peculiar, and has not I think been sufficiently dwelt upon in considering the differential diagnosis of these cases. There is a distinct rhythmical movement of the forearms, which is dependent upon alternate action of the flexors and extensors. This movement is gentle, limited in range and not incoördinate. In the earlier stages of this affection, and usually only in the early stages, the patient is able to control this spasmodic condition by voluntary movement. This is mentioned by many as one of the diagnostic points, but it does not hold in all cases, and especially is this true in the advanced cases. It is usually stated that patients suffering with paralysis agitans are able to write, that when the voluntary impulse is sent out through the nerves, the muscles are steadied and for a short time the spasm is stopped. In the present case the attempt to write has very little effect on the spasmodic movements.

This second case is interesting for two or three reasons. This man is afflicted with irregular spasms of the muscles of the face, neck, trunk, arms and legs. These spasmodic contractions are wide in range, causing the patient to gesticulate, squirm and grimace in a grotesque and conspicuous manner. He has but little control over these motions; and they continue incessantly during the absence of voluntary movement. If you saw a child of ten years of age exhibiting such movements, you would at once say that it was a case of chorea. This patient, however, is rather more advanced in years than is usual for the development of chorea. There is also a distinct family history of this disorder. You notice the difference between the movements of this man and those of the woman to whom I have called attention. She has the constant rhythmical spasms of paralysis agitans; he has the incoördinate action of the muscles of the arms known as chorea. I might state here that in paralysis agitans, the muscles of the neck are

rarely involved. The tremulous motion of the head is due to the shaking of the body from the tremor of the extremities. In this man there is marked movement of the muscles of the neck. We have tried to reach some other diagnosis in this case than chorea. I thought at one time that there was a degree of ataxia which might warrant a diagnosis of one of the ataxic states. I am now inclined to think that it is a case of chorea, depending in some peculiar way upon hereditary taint. What that is I am unable to say. I do not recall having ever heard such a distinct family history of chorea as this man gives us. The patient tells us that his grandfather, and two of his father's brothers had this condition. One paternal aunt suffered in the same way. His aunt married and raised a family of children before the trouble appeared. The patient's father died young, and never suffered with this affection. As far as the patient knows, none of the family had fits. He, himself, never had chorea when young so far as I am able to determine. His present age is 43 years, and the trouble began seven years ago.

This case presents decided distinctions from the ordinary chorea of childhood. Chorea of childhood is not an hereditary affection. As you have heard this man has given a distinct history of the affection coming on in other members of the family in adult life. The patient was himself 36 years of age when the disease appeared. This condition seems not to be amenable to treatment. He has been given the ordinary specific remedies for chorea without effect. What underlies this condition is a subject for speculation. It was at one time thought that this might be a case of what is known as Friedreich's disease, which affection might be called hereditary locomotor ataxia. It comes on within a few years after birth and consists of a congenital lack of development, producing early degeneration of the lateral tracts together with the posterior columns of the cord. This leads to a form of ataxia not unlike locomotor ataxia. Such cases, however, do not have the lancinating pains and the lesions of sensation that are seen in locomotor ataxia. This patient evidently does not belong to this class.

This colored boy, the last case which I shall show you, is by far the most interesting of all. In the effort to differentiate these conditions, there has been mapped out by neurological writers a certain indistinct type of disease which has been called *para-myoclonus multiplex*. This term means a more or less universal clonic spasm of the muscles. This affection also was first described by Friedreich. I have brought this colored boy before you to-day to serve as a text for a few remarks upon this affection. He presents certain multiplex myoclonic phenomena to a marked degree, although I am disposed to think that there is some organic change in the cord, such as disseminated sclerosis, to account for the condition present. Friedreich described the first case of this disease reported, that of a patient fifty years of age suffering with phthisis, who after a severe shock suffered for some time with a condition of almost tetanic rigidity. This was followed by a condition of clonic spasms in the muscles of the arms, the trunk and the limbs, varying in rapidity from ten to fifty per minute. These clonic spasms continued more or less persistent until the death of the patient from the disease of the lungs. I believe that at one time they were partially relieved by the galvanic current. Several other observers have since then put on record cases of a similar character. These cases were unassociated with any loss of consciousness. The peculiar clonic conditions have not been exactly alike in all the cases reported, and they probably differ in their causes and pathology. In some the clonic spasms have been paroxysmal. Hammond has described a condition of convulsive tremor, more or less closely allied to this condition, but in which the spasms occur in paroxysms, the patient having immunity for a long period of time. Some of these cases are much worse on voluntary movement, while others are made better. In some of these cases there is associated a more or less tetanic condition.

In the present case there are three distinct forms of movement. As he sits before you, you will notice a choreiform movement of the muscles of the arms and of the trunk, which is constant, and not associated with voluntary movement. There is another variety of movement which is seen in certain forms of mental weakness and imbecility, and also occasionally in hysteria and hypochondriasis, which is a peculiar acquired movement. He has a curious habit of slapping one hand on the other when a little agitated and when talking. Neither of these movements is of the nature of pure myoclonus. When talking you observe that he has one or two set expressions which he always uses. His intellectual capacity is not very great. Every time that he speaks he exhibits this automatic movement of one hand upon the other. This is not choreic.

He has still another interesting form of motor disturbance. When he puts his feet

upon the floor and attempts to walk, his legs are thrown into a more or less tetanic or rigid condition, which is not a true spastic spasm, but consists of a series of clonic contractions of the muscles of the thighs. This is especially well marked when he attempts to sit down. The patellar reflexes are decidedly increased. The slightest tap over the patellar tendon causes a very marked contraction of the quadriceps. There seems to be no ankle-clonus.

The facts which have made the strongest impression upon my mind are that these three types of movement are presented in one case, and that the condition of the lower limbs is the one which is more distinctly related to these multiplex myoclonic phenomena than I have ever seen it before. As in many other cases in this hospital, we have been unable to obtain much history of this patient. As far as we can make out this condition has come on within the last two or three years. It is not associated with other evidences of degeneration of the central nervous system. There are no areas of anæsthesia. The eyes have been examined by Dr. De Schweinitz, and no appreciable alteration in the eye-ground found. I think that in this case, the diagnosis lies between some form of disseminated sclerosis and the motor phenomena described under the head of para-myoclonus multiplex.

In a certain number of cases we have a degeneration of the central nervous system known as disseminated sclerosis or sclerosis in plaques. In this affection there are little islets of degeneration over the cortex, and involving more or less the other structures of the brain and extending downward into the cord. This produces a special alteration of motility which is to be diagnosed from the other conditions already referred to. In this affection we have, especially in the arms, a degree of ataxia which it is necessary to differentiate from paralysis agitans. In the latter we have the peculiar rhythmical character of the spasm, and the fact that it is more or less controlled by the will. In disseminated sclerosis we have just the opposite. When the patient attempts to make a voluntary movement the motor impulses passing down the lateral columns of the cord are more or less broken up and interrupted by these islets of degeneration. As a consequence we have a series of spasmodic movements which are more ataxic in character than choreic, and which have not the rhythmical character seen in paralysis agitans. It so happens that in this form of disseminated sclerosis these islets become more and more numerous in the cord, and set up in the lateral columns a process of degeneration running down the motor tracts of the cord. The result is that while we still have this condition of ataxic jerking movement in the arms, we are apt to have in the lower limbs a condition of spastic paraplegia. This man has more or less of this condition. He has what is very characteristic of disseminated sclerosis —marked increase in the patellar reflexes. I feel somewhat in doubt about the diagnosis, because in his arms he does not present the characteristic conditions of disseminated sclerosis. He has not the jerking movement of this affection. He has, however, this constant choreiform movement entirely independent of volition. I should call it a case presenting rare multiplex myoclonic symptoms, probably the expression of an insular degeneration in the central nervous system.

COMMUNICATIONS.

TREATMENT OF PLACENTA PREVIA. A HISTORICAL AND CRITICAL SKETCH.[1]

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Placenta previa occurs so rarely that the practitioner is especially dependent upon the literature of the subject for the foundation principles upon which to base successful treatment. The frequency of its occurrence is variously estimated by authors.

Johnson and Sinclair,[2] of the Rotunda Hospital, gave it as 1 in 573; Schuey,[3] 1 in 1564, among 519,328 labors in the Grand Duchy of Hesse; Müller,[3] 1 in 1078, based on 876,432 births; Lomer,[3] at least 1 in 723 deliveries in Berlin.

The placenta is said to be previa "when it is attached to any portion of the uterus which is subject to distention during labor" (Lusk). Placenta previa is central or complete when only placenta can be felt after dilatation of the internal os. It is partial or incomplete, when after dilatation of the os, the membranes as well as the placenta can be felt. It is marginal, when the placental border reaches the internal os; and lateral, when attached within the zone of distention, but where the placental border does not extend to the inner os.

[1] Arranged from a paper read before the Northern Medical Association of Philadelphia, April 13, 1888.
[2] Playfair, Sys. Midwif., p. 394.
[3] Lomer, *Am. Jour. Obstet.*, Vol. XVII, p. 1248.

Lateral implantation is often an unrecognized cause of so-called accidental hemorrhage. The amount of hemorrhage and the mortality vary with the variety of placental insertion. It is generally admitted that the source of hemorrhage in placenta previa is the lacerated utero-placental vessels. Mackenzie[1] in a series of experiments on pregnant bitches, where he partially detached the placenta, demonstrated that the blood flowed from the bared uterine wall, and not from the surface of the placenta. The abandonment of the teaching of Hamilton and Simpson that the source of the hemorrhage was from the partially separated placenta, has greatly influenced modern practice.

Various explanations have been given as to the cause of hemorrhage during pregnancy. The first theory was that obliteration of the cervical canal by being drawn up into the cavity of the body of the womb in the later months caused a spreading out of the internal os, and partial separation of the placental attachments. This was naturally abandoned as being generally applicable, when it was shown that the supposed shortening of the cervical canal did not occur at all, or only in the last weeks of gestation.

The theories of Jacquemier and Barnes as to the relative frequency of growth of the placenta and uterine wall, must likewise be abandoned. For not only are they diametrically opposite, but also they are negatived by the fact that cases of placenta previa frequently go to term without hemorrhage; were either true, hemorrhage would be inevitable during the last three months of pregnancy.

They are further opposed by the admitted observation that placenta previa is a not uncommon cause of abortion. Finally, Matthews Duncan[2] asserts that the causes are the same as where hemorrhage occurs during gestation with a normal insertion of the placenta; that while its occurrence is favored by the abnormal position of the placenta, it is a purely accidental phenomenon, and in no sense inevitable. This view is favored by the fact that it not uncommonly does not occur till labor at term. Aside from occasional rupture of a vessel, and partial separation of the placenta from blows, jerks and falls, hemorrhage may at any time take place from detachment, brought about by uterine contractions. That intermittent uterine contractions are present from an early period of pregnancy, has been shown by Braxton Hicks,[1] and is universally admitted. And as Playfair[2] observes, "there is no reason to suppose that these contractions do not affect the cervical, as well as the fundal portions of the uterus; and in cases where the placenta is situated partially or entirely over the os, one or more stronger contractions than usual may at any moment produce laceration in that neighborhood." This view is accepted by Spiegelberg and King,[3] and certainly best accords with the various conditions.

During labor, hemorrhage is caused by the loss of relation from dilatation of the os and lower uterine segment. But even here it is not inevitable. "Although," says Cazeaux, "hemorrhage is usually considered to be inevitable under such circumstances, yet it may not appear even during labor; and the dilatation of the os uteri may be affected without the loss of a drop of blood." A recent case of my own substantiates this, for while interference was not used until the head was on the perineum, yet the labor was concluded without the loss of blood. Hemorrhage is apt to be less where the fetus has been dead for some time, so that retrograde changes have occurred in the utero-placental vessels. Simpson has shown that where the placenta is expelled before the birth of the child, hemorrhage generally ceases. The investigations of Barnes and Duncan satisfactorily explain these cases. Barnes has demonstrated that separation need only occur for a certain distance within the os; after which, with strong uterine contractions to seal up the mouths of the torn vessels, hemorrhage ceases; that hemorrhage ceases after complete detachment, not because it is complete, but because it is detached from the area of dangerous implantation; that in the cases where hemorrhage is absent, the pains have been sufficiently strong to separate the placenta from the cervical zone before flooding occurs. Strong contractions are necessary to prevent subsequent hemorrhage. Some of these cases may be explained upon the ground that in the region of the os at term, intimate vascular connections do not exist. I am sure that this was true of my case already referred to.

The prognosis is variously stated. It depends largely upon the degree of implantation, and also upon the method of treatment. According to Lusk, one mother out of four dies during or shortly after delivery, and nearly two out of three children are born

[1] Playfair *l. c.*, p. 397.
[2] Playfair *l. c.*, p. 398.

[1] Obstet. Trans., vol. xiii.
[2] *L. c.*, p. 398.
[3] *L. c.*, p. 754.

dead. Including deaths from puerperal processes, Müller[1] (1877) estimates the maternal mortality at from 36 to 40 per cent. Among 4,164 cases, collected by Charpentier, Depaul, Simpson, Schwarz, Trask, Müller and King,[1] there were 1,045 deaths—25 per cent. Individual operators have secured better results. Thus: Spiegelberg 102, 16 deaths, 16 per cent.; Barnes 69, 6 deaths, 8.5 per cent.; Hecker 70, 7 deaths, 10 per cent.; Müller 15, no deaths; Hofmeier 37, 1 death, 2.6 per cent.; Behm 40, no deaths; Lomer[2] 16, no deaths; Murphy[3] 23, no deaths; E. Wilson[4] 30, 2 deaths, 6.6 per cent. Nine operators had 402 cases, 32 maternal deaths, 7.9 per cent.

The prognosis for the child is much worse, and as will appear later, no method of treatment materially improves its chances. Authors give it as follows: Schwarz, 75 per cent.; Barnes, 64 per cent.; Müller (average of 2,360 cases), 64 per cent.; Spiegelberg and Braun, 50 per cent.; Lomer,[5] Hofmeier and Behm (178 cases), 60 per cent.; Murphy[3] (23 cases), 57 per cent.; King,[6] 57 per cent. (Partial placenta previa, 41 per cent.; complete, 66 per cent.)

Placenta previa has been recognized as a complication of labor since 1685, when Portal wrote on the subject. Levret, Smellie, Roederer, Rigby, Barnes, Braxton Hicks, Greenhalgh, Thomas and Murphy may be mentioned as prominent among those who have contributed to a knowledge of its nature and treatment.

Treatment.—King[7] reports 33 cases where no treatment was used. In 11, there was complete, in 11, partial placental presentation, and in 11 this was not noted. In 14, the hemorrhage was moderate; in 6, profuse; in 13, not reported. The maternal mortality was 33 per cent.; fetal, 58 per cent.

Accouchement forcé.—One of the oldest methods of treatment is that of forced delivery. One or two fingers were inserted through the os, then the entire hand, after which the fetus was turned and rapidly extracted. Contusions and lacerations of the cervix were inevitable[8], and the result so deplorable that the method was and is universally condemned. Müller[1] reports 92 cases of *accouchement forcé* followed by version, with a maternal mortality of 47.8 per cent.; fetal, 62.7 per cent.

Rupture of the Membranes.—This measure was proposed by Puzos. It is claimed for the method that by evacuating the liquor amnii it stimulates the uterus to contract, and thus arrests hemorrhage. It has the endorsement, among other modern authorities, of Barnes and Playfair.

Barnes[2] says that "the puncture of the membranes is the *first thing* to be done in all cases of flooding sufficient to cause anxiety before labor." But as King,[3] Müller and Lomer[4] have shown, in a considerable percentage of cases, hemorrhage does not cease after the manœuvre—a serious matter where the membranes have been ruptured with an undilated os. It is now difficult or impossible to do combined version. The ovum no longer acts as an internal tampon, and concealed hemorrhage is apt to occur if the vaginal tampon is employed as is advised.[5] Hemorrhage ceases most often after rupture of the membranes, in cases of partial or lateral implantation. Shroeder, Cazeaux, King[6] and Murphy,[7] advise rupture only after a certain amount of dilatation. Hence, we may conclude that rupture should not be practiced early, except as a step in Braxton Hicks' method. King[8] reports 24 cases, with a maternal mortality of 8 per cent.; fetal, 42 per cent. Fourteen of these were cases of partial placenta previa, and in only nine was the hemorrhage severe. The two maternal deaths he ascribes to early rupture of the membranes.

The Tampon.—Leroux is usually credited with introducing the tampon treatment in 1776; but according to Parvin,[9] this author mentions no instance of its use in placenta previa, and to Wigand must be given the honor.[10] Wigand did not use the tampon

[1] Lomer *l. c.*, p. 1241.
[2] *L. c.*, p. 1242.
[3] *Medical Press and Circular*, Vol. II, p. 206 (1885.)
[4] Parvin's Obstet., p. 327.
[5] *L. c.*, p. 1247.
[6] *L. c.*, p. 750.
[7] *L. c.*, p. 765.
[8] Rigby was aware of this, and mentions deaths from post-partum hemorrhage, with a firmly contracted uterus. He says that in these cases Naegele found cervical lacerations, *post mortem.*

[1] Ency. Obstet. and Gyn., Vol. III, p. 222.
[2] Obstet. Operat., p. 376.
[3] *L. c.*, p. 771.
[4] *L. c.*
[5] Playfair, *l. c.*, and Barnes.
[6] King, *l. c.*, p. 776.
[7] Murphy, *Med. Press and Circ.*, Vol. II, 1885.
[8] *L. c.*, p. 771.
[9] *L. c.*, p. 321.
[10] As bearing upon this point, the following quotation from Rigby's Midwifery (The Library of Medicine, by A. Tweedy, Vol. vi., p. 260) is of interest: "If, after the commencement of a flooding we favor the formation of a coagulum by means of a plug, are we not aiding nature? It brings on labor much sooner, and the os uteri has time to dilate without further loss of blood."—(Leroux, *sur les Pertes de Sang*, § 309.)

exclusively, as exceptions, he says: "It cannot be applied with women whose birth-passage is so irritable that they cannot retain the tampon, even for the space of fifty minutes; so, too, one would act very unreasonably, and even criminally, were he to use the method when called to a woman who had bled almost to death." [1]

Wigand states that he saved all the mothers and children where he used the tampon. This statement, together with his references to feeling the bag of waters, would indicate that he was not dealing with cases of central implantation. Certainly no one's results since, have equalled his. The tampon and internal version have been the methods in most general use during this century. Besides the classical tampon the followers of Barnes have used his hydrostatic dilators, which have the advantage of dilating the os while restraining hemorrhage, and the Vienna school under Karl Braun have largely employed his colpeurynter. The colpeurynter is useful to dilate the vagina in primaparæ. The object sought in the use of the tampon is to restrain hemorrhage while the os dilates. The uterine vessels are compressed by the tampon below and the ovum above, and whatever hemorrhage occurs adds to the pressure. The tampon also restrains hemorrhage by exciting uterine contractions. After dilatation is secured, delivery is effected by the natural powers, version, or the forceps. King,[2] in 75 cases reports a maternal mortality of 25 per cent.; fetal, 53 per cent., although the cases were relatively favorable. Especially where the tampon was followed by version was the result bad—34 cases, 35.7 per cent. maternal mortality; 61.7 per cent. fetal. Charpentier [3] reports 65 cases (Parisian clinic), with 35 per cent. maternal mortality. The tampon was followed by spontaneous delivery, version, or the forceps.

Ergot.—This is given by Auvard as the method of Paul Dubois. According to Parvin[4] the results of this method are a maternal mortality of 42 per cent.; fetal, 77 per cent. But while this is true where ergot is relied upon exclusively, it is not where it is given after dilatation is secured. Murphy [5] and E. Wilson both use it freely at this time, and together they had fifty-three cases with only 2 maternal and 21 fetal deaths. King's [1] table also shows that ergot is a useful adjuvant.

[1] Parvin, *l. c.*, p. 321.
[2] *L. c.*, p. 775. The general mortality was only 22 per cent.
[3] *L. c.*, p. 220.
[4] *L. c.*, p. 323.
[5] *L. c.*, p. 208.

Complete Detachment of the Placenta.—This is usually given the method of Radford and Simpson.[1] It is now purely of historical interest, since the premises upon which it was based have been proved to be false, and also because its maternal, and especially its fetal mortality was high. Simpson in 141 cases gives maternal mortality, 13.6 per cent.; fetal, 79 per cent. But Water and Trask in 94 cases had a maternal mortality of 24 per cent.; fetal, 75 per cent., and Hecker a maternal mortality of 27.5 per cent.[2] King's [3] table in 22 cases of central placenta previa gives a mortality of 18 per cent. and 77 per cent., respectively.

Podalic Version.—Since the days of Portal, until recently, internal podalic version has been resorted to in cases of alarming hemorrhage from placenta previa.[4] It was a part of the old method of forced delivery, and afterwards was used after the tampon or other method of treatment. Müller [5] collected 860 cases of internal version with a maternal mortality of 30 per cent. King,[6] 115 cases, maternal mortality 23 per cent.; fetal, 60 per cent.; in 63 cases version alone was used, mortality 22 per cent.

Forceps.—The forceps do not appear to have been largely used. They can scarcely be applied in the central variety, and dilatation is always a pre-requisite. When used within the uterus, in addition to the recognized dangers of the high operation, there is greater liability to rupture of the inferior uterine segment, from the increased vascularity present, with subsequent hemorrhage. Charpentier mentions 9 cases, with 4 maternal and 6 fetal deaths. King reports 10 cases of which 3 mothers, and 6 children died. It would seem best to reserve the forceps for those cases where the head is in the pelvic cavity, and uterine inertia is present.

The foregoing are the methods which, until recently, have been employed, singly or combined, in the treatment of placenta previa. Including all cases, all varieties of placental presentation, cases in which nature effected the delivery more or less assisted by these measures, and those in which version or the forceps were employed, the maternal

[1] Portal and Smellie both practiced this method.
[2] Charpentier, *l. c.*, p. 223.
[3] *L. c.*, p. 772.
[4] Portal had excellent results. He details fourteen cases, and lost but one mother. Besides he "had saved divers other women in the same condition in the hospitals in Paris." (Translation Compleat Practice of Men and Women Midwives, London, 1763.)
[5] Charpentier, *l. c.*, p. 221.
[6] *L. c.*, p. 778.

mortality is at least twenty-five per cent.; fetal, sixty per cent. Müller estimates that, including deaths from puerperal causes, forty per cent. of the mothers die. This mortality condemns the methods, for by others, better results can be obtained.

Fifty years ago Dr. Renton[1] said that "Portal, in 1672, knew as much on the subject of uterine hemorrhage occasioned by the displacement of the placenta from the os uteri, and the practice necessary for its suppression, as we do at the present time." Fortunately this is no longer true. Since that time there have been introduced the methods of Barnes; the induction of premature labor; Braxton Hicks' combined version, and the method of Murphy.

Barnes' Method.—Barnes wrote on placenta previa in 1847-57, and his theories and practice have changed but little since. His method is best described in his own words.[2] "1. Rupture the membranes. 2. Apply a firm binder over the uterus. 3. A plug may be applied to gain time, but it must not be trusted; watch closely. 4. Separate all the placenta that adheres within the lower zone, and observe closely. If no hemorrhage, wait awhile. The uterus may do its own work; if not dilate the cervix with the water-bags. Again pause and observe. If nature fails to deliver we resort to the forceps, which gives the best chance for the child, or turn." Dr. Barnes has reported sixty-nine cases with a maternal mortality 8.5 per cent.; fetal, 67 per cent. He makes the unfounded claim[3] that his method has saved more mothers than any other. We believe that Barnes' greatest claims to notice should be based upon his opposition to forced delivery, his teachings concerning the lower uterine segment, and his introduction of the water-bags.

Induction of Premature Labor.—In 1864, Dr. Robert Greenhalgh read a paper before the Obstetrical Society of London, entitled "Practical Remarks upon the Treatment of Placenta Previa,"[4] in which he advocated this practice. His views were accepted by Drs. Barnes, Hicks, Hewitt and Oldham. T. G. Thomas, in 1868, advocated the same practice. To these two men belong the credit of systematizing and formulating this method of managing placenta previa.[5] In 1877, Thomas wrote a paper on the subject, in which he reported eleven cases, with one maternal death from sepsis. The advantages of the method are obvious. The mother has not been drained of life's fluid by repeated hemorrhages. She is saved the mental agony of fear induced by the fearful floodings that so often occur during the last three months of pregnancy. She is ensured a medical attendant in her hour of need. Above all, her chances for recovery are increased. The infant's prospects, also, as has been amply demonstrated, are conserved by the method. The physician is enabled to have counsel or assistance, and to conduct the labor in an orderly and systematic manner. Labor is best induced by dilatation of the os with Barnes' bags. When dilatation is secured, bi-manual version may be done, or if the presentation is marginal or lateral, the membranes ruptured, and nature, perhaps, assisted by the forceps, left to complete the delivery. With Murphy and Wilson we may give ergot freely after the os is dilated. When called during a hemorrhage the tampon should be used till a consultation decides upon the induction of labor, or if the hemorrhage is severe we may proceed at once with bi-manual version, sufficient dilatation being present to introduce one or two fingers. The only period at which this method may be questioned is before the viability of the child. The results are as follows: Hecker, of 40 women lost but 3, while his general mortality was 10 per cent.; Hoffman, in 33 cases lost 2; Spiegelberg, in 74 cases lost 4, or 5 five per cent., while his general mortality was 16 per cent.; Murphy lost no mothers.[1]

Bi-manual Version; the method of Braxton Hicks.—In 1860, Braxton Hicks[2] read a paper before the London Obstetrical Society on a new method of turning the bi-manual, especially as applied to placenta previa, and reported six cases thus treated. The method was suggested to him by the success of Wigand and his followers in performing version by external manipulations. In the cases reported he turned by the bi-manual method as soon as he could introduce one or two fingers through the os, pulled down a leg as a tampon, and waited. I quote the following from his paper: "I have in all cases narrowly watched for any external or internal hemorrhage without having met with it. * * * Turn, and the danger is over if you employ the child as a plug; wait then for the pains, and let nature, gently

[1] *Edin. Med. and Surg. Journal*, July, 1837.
[2] *Brit. Med. Journal*, Mar. 3, '88, p. 460 and 461.
[3] *Brit. Med. Journal*, March 3, '88.
[4] Obstet. Trans., Vol. V.
[5] Both Portal and Baudelocque advocated this practice.

[1] Charpentier and Lomer, *l. c.*
[2] Obstet. Trans., Vol. V, p. 222.

assisted, complete the delivery."[1] There can be no question that much of the success of Barnes and Murphy has been achieved through the use of this method, for both employ it when they turn. But in Germany it has found its strongest exponents. Hofmeier first tried it. He had 37 cases, with one maternal death. Behm, encouraged by Hofmeier's success, employed it in 40 cases, and all recovered. Then Lomer had 16 cases with no deaths—93 cases, 1 death, 1 per cent. Eight other assistants had 85 cases, 7 deaths. Total, 178 cases, 8 deaths —4.5 per cent. mortality.[2] No other method has yielded such results in so large a number of cases. The only objection to be urged against the method is the theoretical one that turning increases the fetal mortality, but the results disprove this, for the fetal mortality was 60 per cent.,[3] which is not above the average. The 178 cases were all treated by bi-manual version. If 58 additional cases, in which various other measures had been used before version was employed are included, the mortality was 21—under 10 per cent. This is an additional argument for Hicks' method. In these cases the Hicks' method was used *in toto*, and chloroform was freely administered.

Murphy's Method.—Murphy operates by no exclusive plan, but makes judicious use of several. He is a strong advocate of the induction of premature labor in all cases of placenta previa after the seventh month and "before that period when the hemorrhage is severe, continuous or frequently recurring." His method may be briefly described as follows: 1. Separate the placenta after the manner of Barnes. 2. Dilate the os with Barnes' dilators. 3. If hemorrhage continues, separate the placenta further. 4. When full dilatation is secured, give ergot freely. 5. "If the placenta is marginal or lateral, and the pains fairly strong, I rupture the membranes and leave the course to nature; or, if the head is well into the pelvis, I may apply the forceps; but in the great majority of cases I perform version, preferably by the combined method, and deliver the child as quickly as is consistent with the safety of the mother." The forceps were applied twice. Murphy had 23 cases, lost no mothers, and 13 children—56 per cent.[4]

Finally, we believe that the study of the literature of placenta previa justifies the following conclusions:

(*a*) *What should not be done in treating placenta previa:*

1. *Accouchement forcé* should be absolutely condemned. Lacerations of the maternal soft parts are almost inevitable; perhaps, also, death from shock or *post-partum* hemorrhage. The infant's prospects are not improved.

2. The membranes should not be ruptured before dilatation of the os, except as a step in combined version. Perhaps the greater mortality of Barnes over that of Murphy is due to this difference in practice. The manœuvre frequently fails to arrest hemorrhage; and renders subsequent version more difficult.

3. The tampon should not be used as an exclusive method of treatment. "It is a dangerous thing" (Lomer). It should be used only to gain time for more efficient measures.

4. Ergot should not be administered before full dilatation of the os is secured. It is then of value to hasten delivery and prevent *post-partum* hemorrhage. (Murphy, Wilson.)

5. Complete detachment of the placenta should not be practiced. It is very fatal for the child, and improves but little the prospects of the mother.

6. The fetus should never be turned by internal podalic version, unless the method of combined version has failed. The danger of introducing the hand within the uterus (laceration, sepsis) is thus avoided. Moreover, much time is saved.

7. The forceps should not be used, unless the head is well in the cavity of the pelvis, and hemorrhage or *inertia uteri* is present.

(*b*) *What should be done in treating placenta previa:*

1. In all cases premature labor should be induced after the seventh month, and before that period if the hemorrhage is severe, continuous or frequently recurring. This is done in the interest of both mother and child. The os should be dilated by Barnes' bags.

2. In cases of vertex presentation, when the placenta is marginal or lateral, after dilatation is secured by Barnes' bags (with or without partial separation of the placenta), the membranes may be ruptured, and the course left to nature. In some of these cases the forceps will be needed subsequently.

3. Almost all cases of complete and partial placenta previa are best treated by combined version, with slow and gentle extraction. Version may be done "as soon as one or two fingers can be inserted through the os" (the method of Braxton Hicks), or after

[1] Obstet. Trans., Vol. V, p. 234.
[2] Lomer, *l. c.*, p. 1235.
[3] Lomer, *l. c.*, p. 1247.
[4] Murphy, *Medical Press and Circular*, 1885, Vol. II, p. 208.

the os has been dilated by Barnes' bags, and the placenta partially detached (the method of Murphy). Theoretically, Murphy's methed allows of quicker extraction. By either, a maternal mortality of less than five per cent. may be expected.

4. Ergot should be used toward the end of labor to insure firm uterine contraction and retraction.

5. Strict asepsis should be maintained.

THE MANAGEMENT OF THE NEW-BORN CHILD.[1]

BY J. J. CONNER, M.D.,
PANA, ILLINOIS.

The management of the new-born child is a subject which, though simple in name, I have found to be laden with very great responsibility. Physicians and parents alike are not apt to stop to consider the dictum of Jefferson's old professor of obstetrics, who was wont to say: "A child that is born does not surely belong to its parents until it has reached its sixth year; it seems to me that such a child is but a loan, on condition of becoming property, provided it be wisely and safely conducted up to the sixth year of its age, for one-half of the annual product of child-birth perishes in six years." In Chicago for the year 1887, forty-nine and one-third per cent. of the deaths occurred during the first five years of life. "It cannot be that this amazing mortality is an inevitable concomitant of the state of existence, but it must be largely a result of ignorance and carelessness as to the hygienic conduct of the neonatus and young child. It is true that a multitude of children are brought into the world with such feeble constitutions or such hereditary depravity as to render protracted existence and maturity impossible; but the population would find an immense augmentation were a sound discretion to preside over the hygienic management of newly-born children." The question may be very properly asked, when should this management begin? I answer, it should begin just as soon as the head emerges from the vulva.

The head of the child should be supported so that the face may be raised up from the bed high enough to prevent the child, in its first gasp for breath, from drawing up mucus, blood, water or fæces into its mouth, and thence into the air passages. If such an accident should occur, the child ought to be wrapped in a flannel blanket and laid on its back upon a table, with its head hanging low down over the edge of the table, and a coarse-grained towel or a piece of mosquito-netting spread over the mouth and face of the child. While one hand is held tightly over the child's epigastrium, the physician should blow steadily and moderately hard through the meshes of the cloth into the child's mouth. Some of the air blown into the child's mouth enters the stomach in spite of the hand resting upon it, some enters the lungs and a part returns back through the nostrils, bringing with it portions of mucus or other foreign matter, which may be dislodged by the idle hand. I am in the habit, especially if the child rallies, of administering a teaspoonful or two of water, either warm or cold, as is most handy, to wash away any phlegm that may be in the mouth or pharynx of the child. It serves a double purpose, for it generally soon acts as a laxative to the young child.

If the child be born asphyxiated, I try to excite respiration as soon as possible by first placing my hand under the back of the child and gently raising the thorax, and shaking it until I find that insufficient. Then I dash a little cold water upon the child's chest and into its face, continuing the raising, lowering and shaking, and also making alternate pressure and relaxation upon the thorax. If these measures fail, I sever the cord, plunge the child boldly into a warm bath, and continue still to imitate respiration by the Sylvester method. One should not be easily discouraged if he fails to readily excite respiration in the new-born child. One person should be detailed for this purpose and instructed to persevere for several hours in his efforts to procure respiration. I suppose it has been the lot of nearly every one engaged extensively in the practice of obstetrics to see new-born children come to life, breathe, feebly though it may be at first, gradually gain strength, and live, when they had been at first given up to death. It has been said that a new-born child has been resuscitated as late as twelve hours after birth. Holding the child up by the feet and shaking it with its head down, has, it is said, resuscitated it after everything else had failed.

In ligating the umbilical cord I prefer a piece of stout tape, about one-quarter or one-third of an inch broad, to any other material. I use two ligatures; one is put on three or four inches from the navel, and the other about five or six inches from the navel. The cord is then cut with scissors between the two knots. I strip the cord completely of all the gelatin of Wharton before I tie either knot. If the cord is well stripped before it

[1] Read at the Annual Meeting of the District Medical Society of Central Illinois, April 24, 1888.

is tied, it dries up much better and is very much less liable to lead to inflammation of the navel.

The cord and navel are dressed with simple absorbent cotton alone. No grease of any kind is allowed to be put on them. If grease be put upon the navel it will be apt to turn rancid and produce irritation, and possibly lead to inflammation, erysipelas, and umbilical hemorrhage. It is thought by some that an inflamed navel often produces trismus nascentium by reflex irritation and systemic blood-poisoning through absorption of pus, etc., from the neighborhood of the umbilicus. Before putting the child's clothing on, it is thoroughly greased from the head to the feet, preferably with common lard. Special attention is given to the armpits, groins and other creases of the skin. Nothing will clean a child so readily of the vernix caseosa as good fresh lard. I do not allow any soap to be used upon the tender skin of the new-born babe. The face, hands and buttocks, if soiled by fæces, are gently and very lightly washed with a little soft water, into which the yolk of an egg has been thoroughly beaten up.

As the new-born child has the power of generating body-heat but very feebly, it should be dressed in material that will not conduct animal heat away from the body. That material of course should be woolen. I like the very softest and downiest flannel. There should not be a particle of starched goods in the make-up of the child's toilet. The clothes should be made up loose and baggy, somewhat after the style of the "Mother Hubbard" dress. It is not necessary to put on a belly-band if the child's petticoat has a waist-band attached to it. If there is no waist-band I put on a belly-band. It prevents the dressing of the cord from slipping around and getting misplaced or entangled in the clutches of an awkward nurse, and hence is not so apt to be suddenly jerked off of the child's belly or otherwise injured. I think it prevents hernia too, especially in children prematurely born or otherwise undeveloped. A good flannel bandage will go a great ways in preventing colic in the new-born by keeping the belly warm. The best material of which to make a belly-band is an old piece of woolen shawl, cut bias, so as to give elasticity and allow the belly to enlarge as the bowels evolve the intestinal gases through the process of digestion.

For the constipation so often met with in practice with babies, I have come to rely almost exclusively upon the compound licorice powder of the Pharmacopœia. A suppository of soap generally answers every purpose, and soap is found in every household. An elegant mixture is composed of equal parts of castor-oil and glycerine, to which a drop or two of oil of peppermint has been added. By correcting the mother's habit of costiveness it will generally suffice also for curing the habit in the child if it nurses, as all babies ought to nurse their own mothers.

I believe a child should have a full bath every morning of its life the first year of its existence. It should be entirely undressed and made to sit, or laid down, in a bath-tub. Its entire body should be thoroughly washed and rubbed with the palm of the hand. It should then be suckled and again put to bed, where, if it be a healthy child, it will sleep several hours.

I have no doubt that all practitioners will admit that the most difficult thing in the management of the new-born child is the proper feeding of it. It requires very great judgment on the part of the physician to at all times select the proper kind and amount of food which a child requires. It requires great tact and perseverance on his part to see that the mother and nurse faithfully carry out his instructions. A great many mothers are wofully careless and negligent in this important matter; others are ignorant to an alarming degree, and fail to comprehend the most plain and common-place instructions. Some are lazy and almost criminally wilful, and determined not to carry out the instructions left for them. It is needless to say that without a perfect coöperation of physician and nurse, or mother, that but very little indeed can be accomplished; but with a combination of interest by mother, nurse and physician wonders are accomplished.

If the baby has to be fed or raised by hand, the first thing to secure is a proper feeding-bottle. The shape of the bottle itself is to be looked after. A bottle with angles to it, like a common prescription vial, is to be avoided, for it is hard to clean, and a nurse who is slovenly, careless, or in a hurry to stop a crying baby's mouth, will often give a child milk which is contaminated with decomposing materials which are found sticking to the angles of the bottle at its bottom and neck. There is a feeding-flask now upon the market known as the "Graduated Nursing Bottle," and was made at the suggestion of Prof. Louis Starr, of Philadelphia. It is made of transparent flint glass, thus showing plainly the slightest foulness at a glance. The interior surface is made entirely free from angles, and an accurately graduated scale of fluid ounces, and half ounces or tablespoonfuls, is blown in

the glass. This bottle will be found very convenient and easily cleaned, and accurate in measurement, thus combining the essentials of a feeding-bottle.

The nipple for the bottle should be of the best black rubber, so that it will not irritate and make sore the child's mouth. I prefer the milk from a cow which has recently calved to that from a cow whose calf is some months old, or to that from what is commonly called a "stripper." The freshly calved cow's milk is richer in oil globules and more easily digested by the young child than the milk from a cow which has been milked for a long time since calving. The milk from a stripper has more casein in it than that of the newly calved cow, and is consequently apter to curdle into large cheesy masses and give rise to colic, indigestion and diarrhœa. The formula which I have found to correspond best with the mother's milk, is about the following, viz.: Take one part of rich, new cream from the top of the milk-pan and add another pint of fresh milk and two pints of pure water unboiled; sweeten with milk-sugar preferably, but pure granulated sugar answers fairly well and is found now in every house; the whole should be slightly salted and warmed to about 100° F. A child during the first month of its life, should be fed about once in two or three hours during the day, and once in four or five hours during the night. Be careful about over-feeding the baby. Few children die of starvation in this land of plenty. They are nearly all over-fed with cow's milk, which brings about impairment of the gastro-intestinal functions. I have seen children literally starve to death after they had been over-fed to such an extent that they were unable to digest, assimilate and absorb nutriment which they were given. In just such cases as the ones now mentioned, we may be able to rescue a starving babe by the judicious application of cod-liver oil and mere common lard to the body of the child. One half ounce of cod-liver oil well-rubbed into the skin once every four hours, will often save the child, when otherwise it will surely die. The skin of a young child is very porous and will absorb nutriment rapidly. The stomach and bowels should be let alone for awhile during the rubbing in of the oils. I admit that it requires great perseverance and almost blind faith to succeed, yet success will sometimes be achieved where the usual method fails. Those of my colleagues who have never tried this method of feeding may have grave doubts of its efficiency, but I will only call to their mind the readiness with which a great many medicaments are taken up by the skin and appropriated, and I ask why not nutriment as well? Before entirely condemning the method, I bespeak for it a fair trial at your hands. Of course medicines of various kinds may be very appropriately combined with the food substances and administered together. The secret of success of this method I believe to lie in the property of osmosis of the skin, and the small amount of nourishment required to sustain and strengthen a famishing child. After the alimentary canal has had a rest, the digestive organs will then resume their proper functions. All we have to do is to keep the child alive for awhile, thereby bridging over the stream, and we shall have gained our reward. Shall we give small children alcohol? I very emphatically say yes. Why? Because I verily believe it to be a food as well as a powerful, and at times the best, stimulant known to medical science, when used in certain imperative conditions.

PTERYGIUM COMPLETELY COVERING THE CORNEA.

BY JULIAN J. CHISOLM, M. D.,

PROFESSOR OF EYE AND EAR DISEASES IN THE UNIVERSITY OF MARYLAND, AND SURGEON-IN-CHIEF OF THE PRESBYTERIAN EYE AND EAR CHARITY HOSPITAL OF BALTIMORE.

So seldom is a pterygium seen to exceed in its growth the border of the pupil, that some ophthalmic surgeons of large experience have never seen one of more extensive growth, and have consequently written that a pterygium can never shut out sight by covering the cornea, unless one starts from each canthus, and after many years of growth they meet half way over the pupillary area. The fallacy of this opinion I have an opportunity of showing every now and then, and more particularly in the last week. In accordance with professional experiences, three of these unusual cases presented themselves for treatment during one week at the Presbyterian Eye and Ear Charity Hospital of Baltimore.

Case I.—J. M., a man, 72 years old, had a pterygium on each eye, growing from the inner canthus. He had been more or less annoyed with them for twenty-five years. In the left eye the growth, quite a thick one, was encroaching upon the pupillary area and had commenced to interfere seriously with his vision. In the right eye the pterygium in its continuous development had not only completely covered the pupil, but was nearly touching the external corneal margin, so that nearly the whole cornea was covered over by the flesh-like layer. The external

canthus was perfectly free of all conjunctival complications.

Case II.—M. S., a woman, 68 years old, had the growth only on the right eye, and said that it was of two years' duration. She was not intelligent, and I could not get from her whether it had made her blind for that length of time or not. Evidently the starting point of the pterygium from the inner canthus was of much longer duration. In her case the web was a broad one, completely concealing the pupil, and extending half way from the external border of the pupil to the external border of the cornea. There was no growth from the external canthus, and the left eye was entirely free.

Case III.—J. S., a man, 63 years old. In this case the right eye alone was involved. The pterygium was of twenty years' growth. Starting from the common site, the inner canthus, it had slowly encroached upon the pupillary area, and had finally shut it in, in its continuous progress toward the external surface of the eye. The pupil could be seen only by looking very obliquely through the small rim of clear cornea on the side of the external canthus.

It was the presentation of these three cases for treatment on nearly consecutive days that attracted especial notice, and induced me to report them.

Society Reports.

AMERICAN MEDICAL ASSOCIATION: SECTION WORK.

First Day, May 8, 1888.

SECTION ON OBSTETRICS AND DISEASES OF WOMEN.

The meeting was opened by the President, Dr. Ely de Warker, of Syracuse, N. Y., who welcomed the members to the present session, and delivered his address on the subject

How Gynecology is Taught,

in which he discussed the various methods of instruction, and concluded by paying a glowing tribute to American gynecology, and especially to its founder, Marion Sims.

Dr. Price, of Philadelphia, next followed with a paper on

Free Nursing as Organized in Philadelphia.

He described the system which had been there adopted of furnishing the poor and indigent with skilled nurses, by which operators were enabled to perform even most difficult operations in the homes of the poor, with proper assistance.

This institution was organized two years ago by two charitable ladies of Philadelphia. It is supported by voluntary contributions and such small amounts as the patients are able to contribute. The corps consists of seven well-trained nurses and their assistants. Two maternity nurses attend to the obstetrical part of the work, and separate nurses are employed for the care and attendance of contagious diseases. When an operation is contemplated at the home of the poor the proper nurse at once makes all necessary preparations and everything is brought in readiness for the operation. By this means the worst hovels in the very slums of society are quickly cleaned and made comfortable, so that even abdominal sections can be performed with safety.

This excellent plan is shown by the astonishing result of only *one* death in over ninety abdominal sections. The immense work done is further shown that out of 361 general gynecological cases, 90 were of a surgical character. In this year alone over two hundred cases were attended.

Dr. W. W. Jaggard, of Chicago, next followed with the reading of an essay, entitled

The Relation of Endometritis Gravidarum to the Persistent Vomiting of Pregnancy,

in which he included the report of a case of hyperemesis gravidarum caused by endometritis.

In the case reported abortion was induced by introducing a bougie between the uterine walls and membranes after all other means for arresting vomiting had proven futile. Eight hours later the ovum came away and the placenta was removed according to Credé's method. The fetus was of eight months' gestation. The abortion was immediately followed by cessation of the vomiting. That the vomiting was not due to an artificial displacement of the uterus was proven by the fact that it occurred as late as the sixteenth to the eighteenth week.

Dr. Adams Allen, of Chicago, said he accepted the case reported as a type of cases not infrequently met with it. He arose more particularly, however, to emphasize the method of treating uncontrollable vomiting generally. Most authorities recommend temporarizing and delaying an interruption of pregnancy. The speaker thought such delay proved, too frequently, disastrous. The case reported showed the necessity of departing from such a rule, because a higher value should be placed upon the life of the mother than the child. The speaker now did not hesitate to induce abortion at an earlier

period than formerly, believing that thereby he could save life which otherwise might be destroyed. He therefore thought the essayist was perfectly justified in his treatment.

Dr. W. H. Wathen, of Louisville, was particularly interested in the subject of pernicious vomiting in general. He had seen but one case of truly uncontrollable vomiting, in the practice of another physician. The patient was two or three months' pregnant, and could retain absolutely nothing on her stomach, not even a tablespoonful of cold water. She was thoroughly emaciated.

The speaker at once dilated the cervix to the depth of one inch and a half by means of a steel dilator, not for the purpose of inducing abortion, but as a means of arresting the vomiting. Dilatation had previously been practiced by the attendant with sponge tents without affording any relief. After the dilatation, as aboved described, the nausea and vomiting abated, but abortion occurred a few days later. Unfortunately, the patient died of septicæmia sometime later because the attending physician could not remove the placenta entire and left portions of it attached to the uterus. Had the speaker attended the case throughout, he would have removed the placenta by the curette, if necessary. Although dilatation in this case was followed by abortion, it is not always so followed, and in these cases it relieves vomiting as well.

Dr. Nelson, of Chicago, gave his experience in cases in which vomiting is due to flexion, either of the uterus primarily, or due to the displacement of the ovaries or disease of the adnexa.

In one case, a complicating fibroid tumor was the cause of the flexion, and hence also of the vomiting. He would relate a peculiar experience in connection with this matter. He once attempted to introduce a No. 12 English catheter for the purpose of inducing abortion. He allowed it to remain in situ a few minutes and then withdrew it with the stilet. After withdrawal he noticed a white, milky fluid, about twenty minims in amount, exuding from the end of the catheter. He was greatly puzzled to account for it. Had he opened an abscess cavity, or was it some physiological secretion—perhaps the so-called placenta milk? In his consternation, he neglected to save the fluid for examination, and it was therefore lost. It was possible that he had not exerted sufficient force to rupture a blood-vessel, but that the end of the catheter nevertheless passed into one of the uterine sinuses. The patient made an excellent recovery. The speaker believed that the fluid extracted was normal to this body. He requested his hearers to make similar observations if possible and report them to him if they have similar experience.

Dr. Maury, of Tennessee, thought we should always endeavor, if possible, to preserve the fetus, but if the question of the safety of the mother's life arises we should not hesitate to induce abortion. He thus induced abortion three times according to the method reported by Dr. Jaggard.

Dr. Pollard, of New York, suggested the following modification: Instead of introducing a flexible bougie, a harmless and serviceable method is to take a large-sized piece of catgut, double it on itself, thus introduce it into the womb and leave it there. The catgut should first, however, be rendered aseptic. He resorted to this method in an extreme case with perfect satisfaction and good result.

Dr. Morse was of the opinion that in the great majority of cases, abortion results spontaneously, hence the induction of abortion will not be necessary.

The speaker reported two cases. In one the vomiting had lasted three months. After stomach feeding had become impossible, rectal alimentation was resorted to with some success for two or three weeks. Finally, however, it became necessary to induce abortion, which, unfortunately, resulted fatally.

The patient had had a chronic endometritis before marriage. An examination after marriage showed that the disease still continued, but on account of the absence of any great inconvenience the patient declined further treatment.

She then became pregnant and the result was the setting in of excessive vomiting. Abortion was produced by means of the introduction of a sound and tamponing of the upper part of the vagina. The ovum came away in about five hours. As the placenta did not come away entire the uterus was curetted thoroughly. The nausea and vomiting were indeed arrested, but the patient died of heart-clot the next day. The speaker thought that too long a time had been allowed to elapse between the discharge of the ovum and the removal of the placenta. If the uterus had been curetted immediately she would probably not have died. Another similar case reported terminated in recovery.

Dr. Marcy inquired into the relationship of the placental and uterine villi to each other in the case reported by Dr. Jaggard. The speaker was of the opinion that there was a lack of proper relationship of the villi of absorption to those of secretion. At first the development of these sinuses is glandular,

but afterwards another process takes place, and this change is the real cause of the resulting endometritis. It is not really an endometritis—an inflammatory process—but a lack of proper development. He believed Ercolain was correct in his teachings regarding the structure and functions of the utricular glands. In the majority of cases the speaker thought dilatation for the purpose of arresting vomiting was useless, because it produced either death of the fetus or resulted in abortion in consequence.

Dr. Jaggard, in concluding the discussion, entered a word of protest against dilatation of the cervix simply as a means of arresting vomiting. In the largest number of cases it terminates in the premature expulsion of the ovum. He also preferred the introduction of a solid flexible bougie to a catheter with mandrin, on account of the danger of introducing air or septic material into the cavity of the womb.

Dr. Goodell, of Philadelphia, next read an entertaining, and in part humorous, paper on the

Nervous Rectum.

He described the rectum as being sometimes insane, as it were, whilst the rest of the body enjoys perfect sanity. One variety of this neurosis is the hysterical rectum, the muscles being thus affected, but the sphincters more so than the other set of muscles. A frequent form is spasm of sphincter, which renders defecation painful, and hence induces costiveness. These victims become easily addicted to opium eating. When the rectum is loaded a pulsating pain is felt. If there be in addition some ovarian irritation and enlargement the affection becomes very distressing.

Another form the speaker alluded to as the "jealous" rectum. He gave some very ludicrous instances where the rectum put its veto on any attempts at indulging in social intercourse. One lady always began to have an evacuation from the bowels as soon as she received a letter from her husband, and was obliged to delay reading it until the rectal demands had been satisfied. A second individual would soil her bed after any violent mental emotion. All these persons were kept prisoners at home and had to abandon social intercourse.

A third form he described as "follicular colitis" or "membranous enteritis." He found this affection so often in hysterical patients that he looked upon it as a neurosis, just as pruritus, shingles, etc., are nervous skin affections. He found all these forms of rectal trouble as being peculiar to emotional women of high intelligence: none of them belonged to the lower walks of life. The diagnosis between these neurotic troubles of the rectum and disease of the coccyx is readily made by the introduction of the index finger into the rectum and the thumb over the coccyx, showing that this appendage is movable.

The treatment depends on the form of the trouble. He regarded that of Weir Mitchell for nervous prostration as the best. Seclusion, forced feeding, massage and electricity, the latter two equalizing the nervous fluid and stimulating a healthy action of the nerves. As soon as enemata can be borne, they should be administered before bedtime. Suppositories of iodoform act beneficially, and, in case of spasm of the sphincter, stretching of the sphincter ani. Follicular colitis is almost incurable, but may be soothed by means of suppositories of iodoform, antipyrin, etc. Sometimes injections of lime water or Carron oil greatly relieve this trouble. He cautioned strictly against the use of opium in any form, as these patients are very apt to become opium eaters. Altogether the best medication consists in the administration of remedies constitutional in their action. His favorite prescription is the pil. sumbul comp.; Blaud's pill is an excellent remedy, beginning with one pill three times a day, gradually increased until three are taken after each meal. Occasionally he gave as many as five after each meal. Pills composed of the three valerianates (zinc, iron and quinine) are of great value, also pills composed of chloride of gold and soda. When malaria is at the bottom of the trouble, Fowler's solution acts well. The bromides are often needed and may be advantageously combined with the bitter tonics, as the tincture of gentian comp. When the paroxysms are sudden, antipyrine and the hydrobromate of hyoscine are serviceable. Absolute rest of mind and body secured by absolute seclusion in a darkened room is sometimes indispensable.

Specimens and Instruments.

The Secretary, Dr. E. W. Cushing, presented for Dr. Reamy two specimens of tubercular salpingitis, the tubes and ovaries having just been removed by Dr. Reamy.

Dr. Howard A. Kelly, of Philadelphia, next exhibited a number of gynecological appliances for the use of the specialists in this department. A number of rubber sheets of various shapes to adapt this for the different operations, ovariotomy, perineorrhaphy, etc., were shown, their object being to drain off the fluids thoroughly and yet insure cleanliness. An ingenious rubber bed pan was

also shown. A pair of simple leg holders (*Beinhalter*), inexpensive and easily made, were passed around. Among instruments devised by the same gentleman were a speculum for the knee-chest position, a series of glass (antiseptic) catheters, drainage-tubes with flanges, new sponge forceps, knife-blade tenaculum, a modification of the Bozeman-Fritsch catheter, etc.

Cases of Hysterectomy.

Dr. Gordon then gave a brief account of three cases of vaginal hysterectomies, lately performed. He made an earnest plea for an early operation, as it is now assumed that cancer is first local and afterward constitutional. It should be a golden rule, that where a disease has naturally a fatal tendency if left to itself, an operation is justifiable even if it should terminate in death. The immediate mortality in hysterectomy is not very great; Martin reported only eleven deaths after sixty-six operations.

His first patient was 38 years of age; the evidence of cancer was only of six weeks' duration, according to symptoms, consisting of a growth on the posterior lip of the cervix. Vaginal hysterectomy was performed, with complete recovery. In another patient, 56 years of age, who had an offensive discharge and hemorrhages, the operation was followed by immediate recovery. In a third case, where the cancer was of a year and a half's duration, the patient died from supposed inflammatory intestinal obstruction.

Dr. Marcy reported three cases in which Martin had operated in Boston. One of these subsequently died from hemorrhage, the autopsy revealing that one artery had escaped ligature. He could hardly account for this when noticing Martin's thorough method of securing the blood-vessels. Another case died from heart trouble. An autopsy was refused.

Dr. Goodell was still on the fence. He operated twice in this manner; his first patient died of septicæmia on the third day. The second recovered from the operation, but died from hemorrhage in less than six months. In the future he would leave the clamp forceps on the vessels instead of ligating them. In liberating the uterus from its attachments, he first made the posterior incision and hooked down the organ by means of the old obstetric crochet. He thought that in the future, however, he would make no attempt to retrovert the womb, but simply draw it down with the forceps attached to permit drainage.

Dr. Cushing, of Boston, described Martin's method: He hooks down the uterus with a powerful forceps. Alluding to the paper of Dr. Reeves Jackson, at the last International Medical Congress, the speaker said he laid great stress upon the statistics on the period of time a woman lived when not operated on. The speaker would reply as did Dirner, of Buda-Pesth, that five years longer life of misery in one woman does not count against another whose life is greatly improved by operation.

Dr. Goodell said he had had excellent results from the high vaginal amputation—one patient lived fifteen years after this operation had been done, and the stump treated with a mixture of 15 grains of the bichloride to an ounce of collodion.

Dr. Gordon said in reply, that if the whole uterus is out, this is better than having only part of it out. He retroverted the uterus by means of a stiff sound.

SECTION ON DISEASES OF CHILDREN.

Dr. Charles Warrington Earle, of Chicago, read a paper on

Infant Feeding:

(1) Foods for Prematurely Born Children; (2) Mixed Diet; (3) Artificial Foods; (4) Feeding in Acute Disease.

Dr. Earle began by saying it was particularly appropriate to present to the section a brief *résumé* of what Baginsky, the latest German author on diseases of children, writes on the subject.

The greatest mortality in all climes and among all nations is due to the lack of mother's milk. In Berlin, one-half of all children born out of wedlock die within six months, and during the summer months a large proportion of children succumb to errors of diet.

Fermentation of milk occurs only in consequence of the introduction into it of micro-organisms. If the milk be received by a sterilized tube into a sterilized receptacle directly from the udder of the cow, it will not ferment, nor become acid, though kept indefinitely. But except these precautions are taken, the germs always gain access to it; consequently in order to prevent its fermentation, it is necessary to heat it. It can be sterilized by heating to 70 degrees for an hour, by which process the adult bacilli are killed; although it is necessary to repeat the process for an hour each day for four or five days in order to kill the spores. Heating to 100 degrees by a current of steam for one hour will sterilize it completely, but boiling coagulates the

albumen and to some extent changes the milk sugar.

The first process in the fermentation of milk is due to the action of a bacillus, and consists in the conversion of the milk sugar into lactic acid. This process ceases after a small quantity of acid is formed, but if the acid be neutralized by chalk the fermentation will go on until the milk sugar is all decomposed. By the change of re-action of the milk the casein is coagulated. This coagulation is said to be due to the action of the acid and not directly to that of the bacillus. When the milk sugar is converted into lactic acid, another bacillus—bacillus subtilis—attacks the lactic acid and converts it into butyric acid with evolution of carbon dioxide and free hydrogen. This bacillus cannot act on milk sugar unless it is first converted into lactic acid.

Under exceptional circumstances there is formed in milk a substance first discovered by Prof. Vaughan of Ann Harbor, and named by him "tyrotoxicon" (cheese poison). This substance is a crystalline nitrogenous substance, and is supposed to be a ptomaine. When taken, it produces pain at the base of the brain, vomiting or retching, and purging. When given to an animal, similar symptoms are produced. Prof. Vaughan believes this to be the cause of cholera infantum. Tyrotoxicon is formed spontaneously in milk after some months; but it will be produced very quickly if some milk in which it has been formed be added to fresh milk. Its formation seems to be connected with the butyric acid fermentation.

In conclusion, Dr. Earle asserted that nature does not afford, nor can art supply, a substitute for mother's milk. Mothers should be encouraged by every argument possible to nurse their children, and the dangers of too early weaning should be demonstrated to them. If from causes which we cannot control, and which seem rational and valid, a mother cannot nurse her child, then in cities at least, a wet nurse should be procured. A mixed diet is preferable to an artificial one. For very young infants, in lieu of mother's or nurse's milk, cream with barley, rice or oatmeal water, to which milk, sugar and either common salt, phosphate of lime, or lime water, in small quantities, is added, seem to agree best. For older children, cow's milk and the so-called milk foods, are best. It would seem from some recent analyses of cow's milk that if all kinds of fermentation can be prevented, without the task of preparing cow's milk, so that it will agree with infants, feeding will not be as difficult as it has formerly been. It also seems that it is along this line that investigation in the future should be made. We must not only insist that good milk shall be provided, but also that it shall not have in it bacteria. If milk is used, let it be thoroughly boiled, and for a long time. If it is diluted with water, let the water be absolutely pure. If the attempt is made to make it more nutritious by the addition of cream, let it be that which has not already undergone partial decomposition. The sugar added should be pure milk sugar, and if a small amount of wheat and flour should be used, this too should be thoroughly cooked. If artificial foods are used, let the clinical test decide which shall be selected, and when food is found to agree with a child, let the growth and increased nutrition of that child, or its loss in weight and commencing atrophy, be the guide for the substitution of some other food. I cannot designate particular foods for reasons perfectly obvious. Every food has its advocates. Every food has its chemical analyses, which prove without a shadow of doubt that it is chemically and physiologically the only substitute for mother's milk, and yet every one of them sometimes fail us. I will admit that this is true of mother's milk in rare cases, but as a rule let our advice be in the order I now name: Mother's milk, nurse's milk, mixed diet, cream foods, milk foods, malted foods, farinaceous foods, always pure, free from bacteria, and each preparation, whatever it be, frequently inspected.

SECTION ON DERMATOLOGY AND SYPHILOGRAPHY.

The session was opened by an elaborate and exceedingly interesting paper by the Chairman, Dr. Bulkley, on

Syphilis as a Non-venereal Disease.

The discussion on the

"Etiology and Treatment of Eczema"

was opened by Dr. Bulkley, who said:

The question presented for our discussion this afternoon is one of such magnitude that it is manifest that not more than the outlines for consideration can be sketched at present. In the etiology of the disease we have to distinguish between the predisposing and the exciting causes of eczema, between the constitutional state or condition, and the special determining causes of the attack, internal and local. We know as yet nothing of the real internal causation of eczema, except as we can observe clinical facts of the association of certain symptoms or conditions of system in connection with, and apparently

causative of the disease. I believe the first element to be recognized is *debility* in some form or other. Eczema never occurs except as an evidence of lowered vitality, either general or local. The local element will be considered later in connection with the local exciting causes of the eruption.

The evidences of debility in patients with eczema take three general forms: First, those which relate to digestive and excretive functions; second, those which effect the nervous system and present neurotic symptoms; and, third, those connected with nutrition, or the life process of the body, known as the scrofulous or strumous state.

The first of these is by far the most common, forming fully one-half of all cases, and represents what is known as gouty eczema; the second, or nervous causes, may exist alone in a certain proportion of cases, but often enters as an element in patients belonging to the first class; the third, or strumous condition, is less common than the others, and rarely determines the disease alone, without the intervention of the two preceding causes.

This lowered vitality may come from many causes. In some instances simple over-work or worry, producing nervous exhaustion, may induce and keep up the disease. In more cases assimilative debility, manifested by disorders of the digestion and excretions, plays the most important part, while in other instances a strumous condition of the system seems to be the main factor, and in a few instances heredity is an important element.

Digestive derangements are undoubtedly the most important elements to be considered etiologically in eczema, and again and again their effect may be observed by careful study in many cases. Acidity will always aggravate an eruption of eczema of any extent, and constipation will often be followed by fresh outbursts of the same.

Dr. Zeisler, of Chicago, said: there are two theories concerning eczema: The first, advanced by Hebra, that eczema came from local causes. His strong argument in favor of this theory was that he could produce a local eczema in any individual, in any place, and at any time. His successful treatment lent weight to this theory. The second theory, held extensively in England and America, represents eczema as a constitutional disease, due to ill nutrition. The truth probably lies between these two theories. Many cases are no doubt due to local causes, *e. g.*, eczemas of washerwomen, shoemakers, surgeons, exposure to sunlight, etc. These may, however, be explained by individual peculiarities. Many cases are undoubtedly due to internal causes, but to ascribe all cases to constitutional causes is to transcend our knowledge. Eczema in children is sometimes due to nervous causes, as in teething. Rheumatism is a cause of chronic eczema. Disturbances of digestion are too often blamed as the cause of eczema, for the number of cases of indigestion is out of proportion to the number of cases of eczema, except in infancy. Whether eczema be due to organisms or not, remains to be seen; if so, many subdivisions of what we now regard as one disease will have to be made. I believe in local treatment, but my views have, of late, been modified. I limit the use of arsenic to chronic, dry eczema.

Dr. Ravogli said: in considering the etiology, it is necessary to look at the general condition of the individual. The same cause often works differently in different individuals. This is due to the general condition of the skin, whether it is soft or tough. Thus we find that age makes a difference. The symptoms in children are entirely different from those in adults. It is more acute in children, and in old age more chronic and inclined to the scaly form. He did not believe in a scrofulous eczema. Eczema is a catarrhal condition of the skin. Scrofulous subjects may, however, be more predisposed to eczema. Obstacles to the circulation, as scars, fractures, and varicose veins, are sometimes a cause of eczema. Had had excellent results with the use of salicylic acid and resorcin in eczema of children.

Dr. Reynolds, of Chicago, said that the causes of eczema were both local and constitutional. He relied most upon the local treatment, never losing sight of the constitutional condition, which may aggravate or prolong the disease. For the local treatment, he divided eczema into acute, sub-acute and chronic cases. The treatment of the first was soothing, of the second, soothing, and mildly stimulating, and of the third stimulating. The other constitutional conditions, of course, require their proper treatment.

Dr. Rickets, of Cincinnati, said that he had seen a number of cases in the city during the late epidemic of typhoid fever, and had invariably found an excess of acid in the urine. What relation there was between this fact and eczema he did not know.

Dr. Fleisher, of New Haven, said that gouty eczema was a new form to him, and that eczema was due to blood-stasis, either venous or arterial. He believed struma a cause. He considered that Hebra's experiments in the production of eczema proved nothing, nor was it established that it was caused by special occupations. Such coinci-

dence might be due entirely to similarity of conditions. In the treatment he had found arsenic of great value, but he uses it less than formerly. He believed in the three-fold division of the disease. He had obtained good results from mild external treatment, especially from the use of the ointment of rose-water. In some cases he found great benefit from free purgation.

The next paper read was by WILLIAM T. CORLETT, M.D., Cleveland, on

A Clinical Study of So-Called Prairie Itch.

From time to time one meets with reports in the medical press of diseases of the skin, closely allied in symptoms to scabies, yet it is claimed differing therefrom in certain essential details. This is claimed to possess four cardinal diagnostic points: The first, pruritus, is always present but varies in intensity, being in some cases continuous, but in some cases there are periods of exacerbation, notably at the close of the day. The second symptom consists in a papillary eruption varying in distribution. The hands and forearms are most frequently affected, next in order the trunk and thighs, while the face does not always escape. The third symptom, or more properly, etiological feature, has been the *bête noire* of several amateur microscopists, who have ascribed its contagious or infectious nature to a hitherto unlabeled parasite. The fourth distinguishing feature arises from the observation that, although resembling scabies, yet it does not yield to therapeutical measures best suited to that disease. One or more of these features are present in every case of so-called prairie itch.

In 1854 Dr. William Brodie, of Detroit, took the position that prairie itch was unrelated to scabies, which position, if I mistake not, he still holds, despite the advance made in dermatology since then. In the winter of 1885, it was estimated that one person in every twenty in Louisville had the itch. This epidemic, Dr. Hyde, of Chicago, thought was probably due to an unusual series of cold waves from the Manitoba region. A writer in the Kansas City *Medical Index* for August, 1886, describes the group of symptoms herein considered, and concludes that it is not scabies, nor a disease peculiar to this country. Dr. Engstad, of Dakota, however, has made a careful microscopical investigation and has not found the acarus.

In November, 1885, the "new itch" was reported to be epidemic in Portage and Wayne counties, Ohio, and a committee was appointed from the Northwestern Medical Society to investigate the same. The committee reported: The disease for the most part is scabies, due to the acarus scabiei. The treatment and hygienic measures suggested by the committee were successful in exterminating the epidemic.

(The doctor here gave a more or less detailed account of the history of ten cases which he had studied in hospital and private practice, and which belonged to the same category as those he was discussing.)

In May, 1887, I saw several cases of what is popularly known as the Michigan itch, or lumberman's itch, in the hospital of the University of Michigan.

Other cases in many Western towns of Pennsylvania, which claimed to be specimens of prairie itch, were found to range from scabies to phtheiriasis, from erythema simplex to eczema pustulosum, from pruritus to herpes, and from pityriasis to xeroderma. It is not that scabies has disappeared with increasing civilization, but that we lose sight of the clinical fact that the acarus scabiei is only a local irritant, inducing in one a papillary, in another a vesicular eruption, which in another again may become pustular. Frequent bathing will put a limit to this local invasion; thus it is seldom seen on the hands and faces of those who bathe frequently. Again, the senso-neuroses, which become apparent to American dermatologists, often baffle the most skillful. But, from the mass of cases examined, it is apparent that there exists no material for a new disease, but an appalling need of a more thorough knowledge of those we already have.

DR. ZEISLER, of Chicago, opened the discussion of Dr. Corlett's paper by saying that the cause of the so-called prairie itch was ignorance in regard to skin diseases. The doctor related several incidents showing the ignorance of many of the general practitioners with regard to dermatology.

DR. REYNOLDS said that his practice in the West had given him opportunities for seeing many cases of this so-called new disease. He had always found that this diagnosis was made by men who were not well posted in dermatology. All the cases of prairie itch he had ever seen were typical cases of eczema. He saw little of scabies, but many cases supposed to be scabies were, in reality, eczema. The peculiarity of the prairie itch is the appearance of contagion, which is thought to distinguish it from eczema. This imaginary contagion may be due to the fact that all of a family are under the same hygienic, dietetic, and local conditions. Itching seems to be almost contagious, and the scratching ensuing may occasion a disease of the skin.

Second Day, May 9.

SECTION ON OBSTETRICS AND GYNECOLOGY.

ELY VAN DE WARKER, President.

E. W. CUSHING, Secretary.

The second day's proceedings opened with the election of Dr. W. H. Wathen as Chairman of this Section.

Dr. A. B. Carpenter, of Cleveland, was next nominated as Secretary, and, as no further nominations were made, was elected by acclamation.

The first paper read was by DR. L. H. DUNNING, of South Bend, Ind., on

Double Uterus and Vagina.

The paper was illustrated by a number of large drawings on the various malformations of the uterus and vagina, consisting in duplicities of these organs. After explaining the origin of these anomalies from errors in development in the generative organs from Müller's ducts during embryonic life, and presenting the various forms of double uterus and vagina, he gave complete statistics of the number of such cases reported up to the present time. When pregnancy occurs in a double uterus the unfavorable position of the impregnated uterus is apt to cause miscarriage or difficult labor. These abnormalities are usually confined to the uterus and vagina, the ovaries being rarely implicated. This is readily explained by the fact that these organs are developed from separate germinal bands. Of great interest are the anomalies of menstruation. In addition to the healthy action of the ovaries, there must be a communication between the tubes and uterus, and of the latter organ with the vaginal outlet, to establish normal menstruation. If, owing to malformations, there be any obstruction, there may result various anomalies. One-half of the uterus may become impregnated whilst menstruation occurs from the other half, or pregnancy may occur in both divisions, with different periods of impregnation. This departure from normal menstruation shows the important influence of the uterus over this function. The effect of a duplex vagina over pregnancy is but little described by text-books. Whilst impregnation may take place, labor may be delayed at either by the presence of this septum. It may become torn through the progress of labor, or must be artificially divided before the latter can be completed. The essayist said it may be incised, or removed by the galvano-cautery. Personally, he favored excision and suturing the edges. If an incision be made, it should be crucial. The time of interference is of some importance; if the anomaly be discovered but shortly after pregnancy it is better to wait until the fourth or fifth month before operative measures are resorted to, as pregnancy is less likely to be interrupted at this time than in the earlier months. At all events it is better to cut the septum than to allow it to be torn away during labor.

Finally, the author came to the following conclusions:

1. Congenital malformation of the uterus or vagina are more frequent than is usually supposed.

2. Of the different anomalies, uterus bicornis is the most frequent form—over fifty per cent.

3. The fecundity of women thus affected is not materially diminished.

4. As a result, however, difficult labors are more numerous.

5. In all established cases of uterus bicornis pregnancy has thus far occurred.

6. The forms of malformation of the uterus in which abortion or miscarriage are most apt to occur are the uterus didelphys and uterus bilocularis.

7. Both divisions may be pregnant at the same time and in different stages.

8. Disorders of menstruation are very apt to occur.

9. The amount of the menstrual fluid when normal is small.

10. Menstruation may occur simultaneously from both uteri, or one may alternate with the other.

11. The disturbances caused by these anomalies shows the important part that the uterus plays during female life.

DR. W. H. TAYLOR, of Cincinnati, in opening the discussion, stated that in the past two years he had seen two cases of duplicity of the uterus and vagina. One was a case of complete separation of the vagina, the septum extending from the osteum vaginæ up to the os internum of the uterus (os bilocularis). This woman became pregnant, and at term the child, in breech presentation, straddled the vagina and tore a portion of the septum away in its descent. The untorn portion had then to be divided. This case occurred in the Cincinnati Hospital. The other case did not become pregnant. Here the partition extended only from the external genitalia to the os (vagina bipartitus). This is a much rarer form of malformation. Courty says a double uterus without double vagina occurs one hundred times, whereas a double vagina without double uterus only fifteen times.

Dr. Goodell reported a case of double uterus in which he had made an erroneous diagnosis of extra-uterine pregnancy, and as such presented it before his class. He had passed the sound into one horn of the uterus to demonstrate, as he thought, the extra-uterine pregnancy, and he was only prevented from making a serious blunder by observing the contractions under his hands of the pregnant uterus, and the delivery followed a few days afterwards. The diagnosis in these cases frequently becomes difficult.

Dr. Kelly, of Philadelphia, said he had seen six cases, of which one was recorded in the *Medical News*, a uterus septus with vagina septa. The introduction of the Goodell speculum plainly showed the menstrual fluid coming away in drops from each half. He had one case of vagina subsepta, the lower portion of the vagina being divided, whilst the upper was normal. This case presented some difficulty in coition. In another case he removed a parovarian cyst, since which time the patient conceived and passed an ordinary labor. He would call attention to one peculiarity as a means of facilitating diagnosis in bimanual examination, namely, the depression of the fundus in double uterus. Also the flattened shape of the fundus may be recognized in another form, as the famous case of undeveloped uterus of Rokitansky.

Dr. Franklin N. Martin, of Chicago, read a paper on

The Value of Galvanism as applied by Apostoli in the Treatment of Fibroid Tumors of the Uterus.

After briefly recounting the history of this method, with its growing success both in the new and old world, the author describes his improvements as made in the construction of the intra-uterine electrode, by means of which an exact dosage can be attained. The surface of the endometrium exposed to the galvanic current is accurately determined by the size of electrode employed, those used by the author measuring two and four square centimetres respectively. He also exhibited the large abdominal electrode, consisting of a hollow metal disc filled with water and covered by animal membrane, as an improvement over the cake of clay employed by Apostoli. After briefly reviewing the history of cases thus treated by him, the author stated that from January 1, 1887, to January 1, 1888, he had used galvanism over fourteen hundred times in the treatment of fibroid tumors, 653 times in fifteen cases. Of these five were completely cured and five symptomatically benefitted. After describing the method of using the galvanic current for the treatment of tumors the author concluded his paper with the following summary:

1. A means of generating a continuous current of electricity of steady and uniform character, that can give an actual current strength through a resistance of two hundred ohms of five hundred milliampères, is necessary in order to obtain all the benefits of this treatment.

2. Fibroid tumors of small size can be completely absorbed by the proper application of strong currents of galvanism.

3. Hemorrhages from hemorrhagic fibroid tumors can be promptly cured by the local coagulating effect of the positive pole when it is applied intra-uterine. Severe neuralgias, so often accompanying these troubles, can invariably be relieved by three or four applications of this treatment.

4. When the cervical canal cannot be entered by any form of intra-uterine electrode, flexible or otherwise, after repeated trials, a negative galvano-puncture should be made into the presenting part of the obstructing mass of the tumor and an artificial canal opened, which is to take the place of the impenetrable uterine canal in all subsequent treatments.

5. The intra-uterine electrode should in all cases be negative, unless there is hemorrhage or excessive leucorrhœa, when the positive pole is always required. The same patient may, however, present symptoms demanding the use of both poles at successive operations.

6. The strength of the current should depend entirely upon the amount of active surface of the internal electrode, and should be twenty-five milliampères for each square centimeter of active surface in actual contact with the endometrium. If more is used the concentration of the current will be sufficient to cause troublesome cauterization; if less is used the concentration will not be sufficient to cause the necessary coagulation for checking hemorrhage.

7. The duration of the treatment should be five minutes of the maximum current required.

8. The number of operations is necessarily dependent on and influenced by the result to be accomplished. A severe hemorrhage can be checked and symptomatic relief can often be accomplished by four or five seances, while a general reduction of the tumor necessitates many operations, varied, of course, according to the size and location. In some

cases of large multiple tumors a relief of symptoms, or symptomatic cures, must be accepted as a substitute for an actual cure.

9. The operation should be intra-menstrual, if possible; if hemorrhage is continuous, however, operate during flow. The seances can occur as often as every day with the system of concentration adopted that enables one to attack different portions or the canal at succeeding treatments, or this can be given with advantage as few as once a week.

10. Since the adoption of the flexible intra-uterine electrodes and Dr. Apostoli's vaginal galvano-puncture, extra-uterine puncture should be regarded, if at all, only as a last resort.

11. Galvano-puncture needles and the internal electrodes should be constructed of material that is not injured by coming in contact with strong carbolic acid, or 1:1000 bichloride mercury solution. All internal electrodes should be thoroughly scrubbed with a nail-brush and soap and water after each application, and allowed to remain in one or the other of these standard antiseptic solutions until they are to be employed again, when they should be washed in a weaker solution of the same before using. Before a vaginal puncture is made the vagina should be thoroughly wiped out with a 1 to 3000 bichloride solution.

12. There is no excuse for any percentage of mortality in the proper application of this treatment. While Dr. Apostoli had two deaths in two hundred and seventy-five cases, he candidly admits they were due to avoidable accidents rather than to any legitimate procedure of the operation.

13. In experienced hands, and by the adoption of the present means of concentration, the most delicate and sensitive patient can receive, without experiencing any severe discomfort, all the benefits to be derived from this valuable treatment.

Dr. A. B. Carpenter, of Cleveland, O., next described a

New Method for Supplying the Electrolytic Current in Uterine Fibroids.

The author spoke of the difficulty of keeping the ordinary physicians' batteries in good running order, and therefore devised a method of supplying the electric current at any time desired in the proper strength. He took his current directly from the street, using the electric current as furnished by the Edison light for this purpose. The Brush light is too dangerous, but the Edison system, which furnished an electric intensity of 100-110 volts, will not prove dangerous even with the entire strength outside of the rheostat.

The author exhibited the working of his apparatus, with the wires attached from the street.

In opening the discussion, Dr. Newman said that the electric current has always an electrolytic action, the amount depending on the strength used. If the current be small, the current will act as an absorbent; if large, it may prove destructive. He formerly claimed that a strong current should never be used, but in the light of recent developments he took it all back in considering the treatment of fibroid tumors, the large electrode diffusing the strength of one pole over the whole abdomen, overcoming the destructive tendency of a current of too great an intensity. The result will depend upon the concentration of the current upon the electrode. It is true that operators differ as regards the *modus operandi* in their treatment of tumors by electricity. Freeman, for instance, achieved good results with pointed needles. The speaker would, however, warn beginners against using needles with fine points, even in intra-uterine puncture, because it might be followed by fatal results. He himself used an intra-uterine sound, insulated, except at the end, to the depth of the uterus. This he attached to the negative pole and gradually passed it into the womb. If the canal be tortuous, this passing in may, at first, be difficult, but gradually the sound will enter deeper. The opponents to the use of electricity for this purpose say that it does not always cure them. He would reply that the object is not to entirely remove them, but to diminish the size as much as possible, so that they become harmless. If more than this can be done, so much the better.

Dr. Marcy, of Boston, said that for his knowledge of the use of galvanism, for its electrolytic action in tumors, he was first indebted to Dr. Cutter, of New York, whose pupil he was. At that time he saw cases benefited by this treatment, but also saw occasionally dangerous results. He then discarded its use, and was with great difficulty re-converted, until he heard of Apostoli's great success. He then again supplied himself with an electric apparatus, and since then had had unqualified success. If we could utilize the street lamps for this purpose, he regarded it as a great improvement, altogether a new departure. In conclusion, he greatly lauded the advances made by the two gentlemen in this direction, throwing additional lustre upon American gynecology.

Dr. Martin, in reply to a question, stated that the only improvement in his

animal membrane electrode consisted in its greater cleanliness and handiness. His dynamo enabled him not only to obtain high tension, but also a cautery current.

Dr. Carpenter, in concluding the discussion, stated that he always began with a low dosage. He thought it better to employ a longer sitting and reduction of strength in the beginning. Antiseptic precautions should also be instituted. He laid special emphasis upon the importance of rest after each seance. It is his practice to keep his patients at least one hour in his office before permitting them to leave. The great relief afforded at each sitting will often induce women to visit their friends and thereby frequently set at naught all good effects obtained. In conclusion, he narrated an intractable case of vesical irritation, in Cincinnati, which was truly in a pitiful condition. After four treatments the incontinence of urine entirely disappeared and the patient became greatly relieved.

One of the most instructive, as well as entertaining features of this session was the exhibit of micro-photographs, illustrating microscopical

Studies of Endometritis, Adenoma and Carcinoma Uteri

By Dr. E. W. Cushing, of Boston.

The pictures were thrown upon a large canvas from the stereopticon, and were very beautiful. Each picture was graphically and lucidly explained by the exhibitor.

Special Correspondence.

LETTER FROM CINCINNATI: MEETING OF THE AMERICAN MEDICAL ASSOCIATION.

Wednesday, May 9, 1888.

The second day of the Association meeting has been especially distinguished by the report of the Trustees of the Journal, which contained figures indicating that the income of the Journal had increased last year, and that the outlook for its prosperity is very good. I am betraying no secret when I say that there is a deep dissatisfaction on the part of many of the members of the Association here with the way the Journal has been conducted; and there is a feeling that if its increased revenues have been secured by the abuses of its pages by advertisers during the past year, the Association cannot congratulate itself upon this fact.

I hear a great deal of complaint that the Journal is not what it was intended to be, namely, a substitute for the volume of transactions. Men complain that the proceedings of the Association are not properly reported in the Journal, and that the papers are not published in regular order or according to any well arranged plan. They say here that it is too much filled with the proceedings of the Chicago and Illinois societies, and that papers read at the meeting are pushed aside in order to make room for papers which have not been presented to the Association at all, and which were written long after the ones which they have displaced.

In connection with the complaints against the way the Journal has been conducted, much comment has been excited by the fact that the manufacturers of the Ivory Soap have circulated broad-cast at this meeting *fac simile* copies of a letter by Dr. N. S. Davis, endorsing and recommending this soap for use by physicians.

To return to the meeting: Dr. E. A. Wood presented on Wednesday a report from the special committee on dietetics. Dr. Wood has undertaken the work of interesting the Association in this important subject, and his labors were crowned with signal success. His report was listened to with deep attention, was received with the warmest expressions of approval, and its reading was followed by the adoption of a resolution making *Dietetics* one of the regular subjects for discussion at the annual meeting.

The social feature of to-day was a handsome reception by the members of the profession in Cincinnati to the members of the Association at the Art Museum, in Eden Park.

Thursday, May 10.

Among the proceedings of the general meeting to-day Dr. E. M. Moore, of Rochester, N. Y., read the annual address on surgery, which was a very interesting and scholarly document. The committee on the Rush monument reported progress, but announced that the responses to the recommendation of the Association that the members contribute liberally to the proposed monument had been far from satisfactory. The report of the Treasurer of the Association was read and approved.

The section meetings were interesting and well attended; and in the evening a delightful concert was given to the members of the Association and their friends in the Music Hall. This was very largely attended, and was one of the most successful entertainments of the meeting.

It was made known to-day that the Nominating Committee have selected Newport, R. I., as the place for the next meeting, Dr. Dawson, of Cincinnati, for the next President, and Dr. Pepper, of Philadelphia, to deliver the address on General Medicine. The latter choice is supposed to be intended to make up for the failure to accept an invitation to take the Association to Philadelphia next year. The choice of the place for the next meeting has been perhaps the most exciting question before the Association this year. The delegates from the Philadelphia County Society came here bearing a unanimous invitation from their Society to the Association to meet in Philadelphia in 1889. This invitation was understood to be tendered for the purpose of testifying to the good will of Philadelphia toward the Association, and of renewing the friendly relations which had been impaired by certain occurrences during the last few years. There can be no doubt that it would have been accepted, but for the fact that a few medical men from Philadelphia worked hard against it, claiming that the invitation was offered in order to get an opportunity to snub them and a college in which they are interested. It is believed that this fact, together with some arrangements in connection with the name of a candidate for the Presidency, prevented the acceptance of Philadelphia's invitation. Another thing which had some bearing upon the case is the fact that the delegate chosen to represent New Jersey, although instructed by his delegation to vote to go to Philadelphia, actually voted and spoke against this proposition! It is said that his conduct will be inquired into when he reaches home. Those who have heard of it here have expressed considerable indignation at this and other things which are reported of him. If what is asserted of him be true he may well be disciplined by his local Society. If it be erroneous, an explanation from him would probably be appreciated by his colleagues who are here.

While on the subject of the choice of the place for the next meeting, I may say, that this one has been marked by a degree of good-feeling which it is pleasant to note; and, so far as Philadelphia is concerned, there is apparently a complete restoration of the peace between it and the Association, which was of late so disturbed. The invitation which was not accepted was fully appreciated, and I have no doubt it would have been accepted if this had rested with the Association instead of the Nominating Committee.

Friday, May 11.

This was the closing day of the meeting; and, as usual, there was a comparatively small attendance. The business was hurried through; a few attempts were made to get in special resolutions; and an adjournment was effected after the passage of a hearty vote of thanks to Dr. Garnett for the admirable manner in which he has presided over the meeting. This resolution was not a mere form; for the proceedings this year have been entirely orderly and decorous, and have presented a marked contrast to certain others which it might seem invidious to specify.

One of the interesting episodes of the closing hours of the meeting was the introduction of a resolution by an ex-President of the Association — who is said to be a stockholder in a large manufactory of pharmaceutical preparations — that hereafter there should be no exhibit of pharmaceutical and surgical appliances. The reason given for presenting this resolution was that the exhibits distract the attention of the members of the Association from its own business. Certain of the unbelieving here have been so irreverent as to connect the resolution of the ex-President with the fact that the firm, with which he is said to be associated, has no exhibit here.

I cannot say how all these things may be; but this episode contributed materially to the interest of this meeting, and gave rise to some very amusing speeches. The outcome has been that the Association voted down the ex-President's resolution and pronounced most emphatically in favor of exhibits, and the exhibitors go away rejoicing.

So closes what has impressed me as a very successful meeting of the Association. Much good work has been done and I think I have seen the promise of much more to come. As you requested me to limit my correspondence as much as possible to the social and administrative features of the meeting, I have said very little about the scientific proceedings; but I may state in closing, that they appear to me to have been of unusual excellence. This I find is the general opinion, so that the meeting at Cincinnati is likely to be memorable in every way.

Yours truly, J. C. B.

—Dr. Henry Mitchell, State Inspector of the Board of Health, of Asbury Park, has resigned from the local board, of which he was President for eight years. The Borough Commissioners have passed a series of resolutions regretting the doctor's retirement.

Periscope.

Etiology of Floating Liver.

In the *Berliner klin. Wochenschrift*, No. 38, 1887, H. Rosenkranz reports the case of a woman, forty-eight years old, who was at the climacteric and had had eight normal births. In the middle of February, 1887, she was suddenly taken sick with violent vomiting and pain in the pit of the stomach and around the liver. Soon afterwards ascites, œdema of the limbs, genitalia, and skin of the belly occurred. The urine was free from albumin, the heart normal, and there was no jaundice. Through the administration of diuretics and hydragogue cathartics, the ascites and œdema soon disappeared. The general feeling of the patient was good. In May the abdominal cavity was found by repeated examination to be filled with a large tumor, which from its form and mobility was recognized without difficulty as the liver. The gall bladder and all the lobes of the liver could be plainly felt on palpation. The normal area of liver dulness had disappeared. It was now easy, says Rosenkranz, to explain the ascites and œdema. The violent vomiting had effected the separation of the liver from the diaphragm, and hence the violent pain at that spot. The absence in this case of pendulous abdomen is especially noteworthy.—*Centralblatt f. d. med. Wissenschaften*, April 14, 1888.

Boldine, a New Hypnotic.

The glucoside boldine, which is contained in boldo leaves, is said, by French experimenters who have studied it, to have hypnotic properties. It is easy to take, has no bad after-effects, increases the appetite and at the same time strengthens the patient. Doses of seventy-five and one hundred and fifty grains were administered to different patients by Juranville daily, without injury resulting. The sleep which is induced is like natural sleep, and respiration is regular and quiet. Excited, hysterical and other nervous patients who had suffered for a long time with sleeplessness, sank into a refreshing, quiet slumber under the use of boldine. It is given in capsules containing three grains, or hypodermically dissolved in water.—*Deutsche med. Wochenschrift*, April 19, 1888.

Diseases of the Aortic and Mitral Valves of Long Duration.

At a meeting of the Clinical Society of London, January 27, Dr. J. Kingston Fowler described this case, which was that of a man 66 years old, a wood-turner, working a treadle lathe. Physical examination of the chest gave the following results: There was a systolic recession of the epigastrium; the cardiac apex was in the fifth interspace in the nipple line; the impulse was forcible, indicating a moderate degree of hypertrophy of the left ventricle; at the apex the first sound was accompanied by a systolic murmur; at the base, in aortic area, there was a short systolic *bruit*, and the second sound was replaced by a rough diastolic murmur; there was evidence of some hypertrophy of the right ventricle; the valves on the right side of the heart were judged to be competent. The pulse was 84, small and collapsing. The urine was free from albumin. The interest of the case centred in the fact that in 1834 the patient, then a boy aged 13, was admitted into the Middlesex Hospital, under Dr. (afterwards Sir) Thomas Watson, with acute rheumatism, for which he remained under treatment nearly nine months. During the early part of the illness leeches were applied to the præcordium on more than a dozen occasions, and subsequently blisters were frequently used. The evidence upon which it was concluded that the valve lesions now present occurred during the attack of acute rheumatism in 1834 was entirely circumstantial, no written evidence of the case having been found. It might be summarized as follows: 1. The statement of the patient that on a certain occasion two gentlemen accompanying Dr. Watson on his visit, having auscultated the patient's chest, the one remarked that he heard a sound "like an old woman blowing a bellows in a back room;" the other said the sound was more "like to the whistling of a steam engine." 2. The fact that Dr. Watson told the patient's mother on his discharge from the hospital that he was never to leave home without telling her where he was going. 3. That for three years the patient carried a card with his name and address upon it, so that "if anything happened to him suddenly it might be known who he was and where he lived." 4. That he had had no return of the rheumatic attack, and had scarcely been absent from work for a single day during the last fifty-four years. The case was reported as being a rather remarkable example of a stationary lesion of the cardiac valves of rheumatic origin, in which compensation having been established, it had remained perfect for fifty-four years, and now showed no sings of failure. The patient had been shown at a previous meeting of the Society.—*British Med. Journal*, February 4, 1888.

Use of Pessaries.

Dr. Wallace A. Briggs, in a paper read before the Sacramento Society for Medical Improvement, February 21, 1888, says that pessaries must always be regarded as foreign bodies and their irritating qualities reduced to a minimum. This is to be accomplished: 1. By using thick, polished, non-absorbent pessaries. A rough absorbent surface not only irritates mechanically but also furnishes conditions extremely favorable to decomposition and consequent chemical irritation and even septic infection. A pessary with thin bars is much more likely to abrade and perforate the vaginal walls and to interfere with the pelvic circulation than one with thick bars. 2. By educating the vaginal mucous membrane and the neighboring tissues to a tolerance of the pressure, friction, and other causes of irritation consequent on the use of pessaries. This may be done by the use of either antiseptic cotton or antiseptic lamb's wool support. Either of these materials, indeed, but especially the latter, on account of its elasticity, makes an admirable pessary. Previous to packing, astringents, either in powder or in solution, may be applied to the vagina for the purpose of "hardening" it. Some prefer the use of elastic pessaries to test the tolerance of the pelvic tissues. He has not, however, found them altogether free from objection, and ordinarily prefers the antiseptic packing. 3. By accurate adjustment. By no means should the instrument be too large, otherwise the vagina will be unduly distended, irritated, inflamed, eroded, perhaps perforated, and the functions of neighboring organs seriously interfered with. Accurate adjustment relates to form as well as to size. Sharp angles should be regarded with suspicion, if not altogether discarded. One should never attempt to accomplish too much with the first pessary. 4. By occasional, sometimes frequent, removal of the pessary. In this way we obviate the evil effects of continuous pressure. In properly selected cases, therefore, instruct the patient to remove the pessary every third or fourth night on going to bed, and to introduce it again in the morning before rising. In the interval, position may be relied upon to keep the uterus in place. 5. By thorough cleanliness secured by daily cleansing and occasional antiseptic irrigation of the vagina.

Not only, he says, must pessaries be regarded as foreign bodies, but their contra-indications must also be kept well in view. To the neglect of these, he thinks, must be ascribed much of the prevailing doubt as to the value of pessaries. Among these contra-indications may be mentioned fixation of the displaced uterus; either acute, subacute, or some forms of chronic inflammatory affections both of the uterus and of the uterine annexes. Minor contra-indications consist of catarrh and erosions of the cervix, excessive weight of the uterus whatever its cause, extreme flexibility of the uterine walls, and vaginitis.

The author closes his paper with notes of several cases illustrating the benefits which accrue from the use of pessaries in appropriate conditions.—*Sacramento Med. Times*, April, 1888.

Treatment of Loose Cartilage in Knee-joint.

At the meeting of the Harveian Society of London, February 2, 1888, Mr. Herbert Allingham reported a case in which he had sutured the internal semilunar cartilage of the knee to the head of the tibia. The patient was a man, 35 years old, who had been constantly laid up by the slipping of the internal fibro-cartilage of the knee-joint. An incision two inches long was made, with its centre over the cartilage. The knee-joint was opened, and a strong catgut suture passed through the fibro-cartilage and the periosteum of the upper end of the tibia. The joint was washed out with carbolic lotion, and the synovial membrane united with deep catgut sutures; the wound was then closed without drainage. The patient, who was shown to the Society, made a good recovery, and can now follow his employment.—*British Med. Journal*, Feb. 11, 1888.

Pulsating Pleurisy.

A. Keppler, in an article in the *Deutsches Archiv für klin. Med.*, XLI, Heft 3, states that most of the cases of pulsating pleurisy occur on the left side; in a case of Eichhorst's, however, the pleurisy was on the right side. Keppler believes that the condition which occasions the phenomenon is brought about in the first place by a paralysis of the intercostal muscles, which is especially apt to occur in purulent pleurisy. Other factors in its development are a certain pressure under which the exudation exists, which is conditioned especially by sacculation of the latter; and finally, a sufficient power in the movements of the heart. Of course, an airless lung placed between the heart and the exudate is especially adapted to the unaltered propagation of the pulsating movements. As the pulsations are for the most part general, they are differentiated in this way from the pulsations occasioned by aneurism.

THE

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CHARLES W. DULLES, M. D., EDITOR.

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THE AMERICAN MEDICAL ASSOCIATION.

The thirty-ninth annual meeting of the American Medical Association which has just been held in Cincinnati was one which may justly be a source of satisfaction to all the friends of the Association. The scientific proceedings included important papers and discussions by men from all parts of the country, and were unusually full and interesting. The subjects ranged from those of the broadest and most general interest to those of minute and special detail. One of the most valuable addresses was undoubtedly that of the President, Dr. Garnett, who gave a clear picture of the present state of medical education in the United States, and urgently recommended the adoption of suitable legislation to regulate medical education by State authority, and to confine the right to issue licenses to practice to State Examining Boards. The details of this address include some points in regard to which there may be some difference of opinion; but the general principles of it can hardly be dissented from.

Other subjects of general interest were introduced and discussed by other members of the Association. For example, there was an important discussion on pneumonia, in the Section on Medicine, and a sort of symposium upon inflammation at and near the vermiform appendix, in the Section of Surgery; and a very remarkable paper and experimental demonstration by Dr. N. Senn in regard to determining the fact and location of perforations of the intestinal tube in cases of gunshot wound of the abdomen. The Section on Obstetrics and Diseases of Women was largely attended, and its work of the most instructive and interesting character. The same may be said of almost all the sections, while especial mention might be made of the work accomplished in the new Section on Dermatology and Syphilography.

These departments of the Association all showed a high degree of activity, and demonstrated their great usefulness. In the general meetings very little besides routine work was done. The business of the Association was transacted smoothly and satisfactorily. The most interesting subjects considered were probably the conduct of the Journal of the Association, and certain proposed amendments to the Constitution which provide for placing a large part of the administrative business of the Association in the hands of a permanent committee. The latter proposition was laid over for further consideration until the next meeting. The former subject was not discussed openly, although it was very warmly discussed outside of the meeting.

The general affairs of the Association seem to be in good condition. The discord which has so recently exercised an unfortunate influence upon the prospects of the Association seems to be fast disappearing. Some parts of the profession which have been alienated from the National Society appear to have determined to let the past go, and come back loyally to the Association, while the Association itself seems willing to give them a hearty welcome. At no recent meeting has so little of the unfortunate influence of agitation been apparent; and at

none has there been so strong evidence of the good sense and warm hearts of the members of the profession all over our land.

In looking over the whole of this meeting, we feel that there is every reason to congratulate the Association and the members of the medical profession in general, upon the cementing of friendship and advancement of scientific knowledge which it has brought about; and we may look forward with bright hope to the future, expecting the American Medical Association to be—as its originators designed it to be—the chief agent in developing unity of sentiment and increase of scientific attainment among the members of the medical profession in America.

A POINT IN REGARD TO INSANITY AND ITS TREATMENT.

The daily papers of May 1, 1888, report the fact that a clergyman who committed suicide at White Plains, N. Y., on April 29, had some time before confessed to his physicians that he was suffering with melancholia, and had an almost irresistible impulse to shoot himself. It appears, also, that he had already once made an attempt to take his own life, and that his father and brother had committed suicide.

This painful occurrence calls attention to the importance of having persons afflicted with melancholia under adequate surveillance, so that they may not have opportunity to carry out the insane impulses to which they are so peculiarly liable. It is a fact well known to alienists that persons afflicted with melancholia are apt to pass with frightful rapidity from a state in which they suffer with mere depression of spirits into one in which they become dangerous to themselves or to others. Occurrences similar to that mentioned above are so common that it seems utterly inexcusable for physicians to neglect to insist that the friends of persons who develop melancholia should adopt precautions adequate to prevent them. It may at times seem almost cruel for medical men to tell the friends of those under their care that nothing but the restraint of a hospital for the insane can be relied on to save a person with melancholia from doing violence to himself or to others; and yet there is no other way to prevent such catastrophies as must have come under the observation of almost every medical man.

Fortunately, in these days the fictitious horrors of insanity are being dispelled, and it is coming to be regarded as a true disease, which is often amenable to judicious treatment; and subjection to the discipline of a hospital for the insane is not now-a-days regarded as an incarceration. It is not nearly as shocking as it once was to propose this plan of dealing with those whose minds are unbalanced, and medical men should encourage the further growth of a rational sentiment in regard to insanity by showing that they regard it as a disease, and do not shrink from suggesting what they know to be the only reliable means of dealing with it.

By taking a proper attitude toward this whole subject, and making their opinions known to the community, medical men may do a great service to their fellow-men, not only by making it easier when the occasion arises to apply these opinions, so as to avert a threatening disaster, but also by bringing others to regard diseases of the mind with less distress and despair. The ways in which a more rational appreciation of the condition called insanity may be of value to those who suffer with it, as well as to their friends, are too numerous to be mentioned here; but we commend the subject to the reflection of our readers, in the hope that they will give it careful thought, and see if it does not suggest a distinct opportunity of usefulness to their fellow men.

THE HOUSETOP AS A HEALTH RESORT.

The suggestion to utilize the roofs of city houses as a place of escape from the noise and unwholesome conditions of the street-level is by no means a new one. It has been not only made before now, but also acted on; and several large cities have popular resorts high up above the level of the ground, and to be reached only by steam elevators. But, lately Dr. Gouverneur M. Smith, of New

York, has proposed that the roofs of city houses shall be systematically occupied, for the sunlight and fresh air which can be there obtained, and has urged the devising of some plan by which it can be made feasible.

This proposition is one which deserves attention. Unfortunately Dr. Smith makes no suggestion of a plan himself, and no plan has ever been suggested which is of general applicability in the climate of a large part of our country. So, it is hardly likely we think that the day will ever come when a city in the United States shall have its roofs comparable to those of the towns of Syria, which are sometimes called cities. But, we believe something is attainable in the direction of utilizing the roofs for obtaining the benefits of light and air. Access to the roof of every house ought to be as easy as access to any part of it—of course with proper safe-guards against accident to children. In fact, the roof of a house ought to be a sort of pavilion, with a covering which would admit light and exclude the storm in winter, and give free access to the air when the weather is warm. To secure these objects a costly structure would be needed, one with a covering made in part of strong glass, and immovable, so that the sunlight could pass freely through it in winter, and in part of some material light enough to be removed in summer, and strong enough to bear a load of snow in winter. To modify the roofs of many houses now built so that they would fit this description would be very costly; and to construct new houses with such roofs would put a hard strain upon buyers and renters of houses, most of whom cannot afford a larger investment than will furnish them living rooms enough. But we believe it to be not only practicable, but also very desirable for those who can go a little beyond their absolute necessities to make use of the opportunities for light and air which are afforded by their roofs. In winter they could be used as solariums, in summer as refuges from the heat, and in every season they might afford a most delightful place of recreation and amusement.

We commend this idea to the attention of our readers in the hope that some of them may be able to suggest a plan by which they can be carried out.

IMPREGNATION AFTER CASTRATION.

A question which has most interesting physiological aspects, and may have an important forensic bearing is: whether, or not, a man who has had his testicles removed has still, for a moderate length of time, the power of impregnating a woman. This subject has been discussed at different times by a few students of physiology and of medical jurisprudence; but it has never been absolutely settled. The natural presumption is that under these circumstances a man would not be able to impregnate a woman. But—strange as it may seem—this is by no means certain. On the contrary, as the Roman author, Varro, claims to have known an instance in which a castrated bull impregnated a cow, so there are some medical writers who claim that a castrated man may impregnate a woman. The most recent writer on this subject is Dr. N. Obolonsky, prosector in the University of Charkow, Russia, who discusses it in the *Vierteljahrsschrift für gerichtliche Medicin*, April, 1888, principally in connection with a curious set of fanatics called "Skopzen" in that country. These fanatics practice castration as a part of their duty; but are not thereby prevented from indulging in great sexual excesses.

Obolonsky has studied the subject alluded to historically and experimentally, and finds no reason to doubt that, for perhaps a month after removal of the testicles, spermatozoa may be present in the vesiculæ seminales, and may be ejaculated in sexual intercourse. The historical part of his study is interesting enough; but more interesting and more conclusive is his report of the results of experiments he made upon two dogs, which showed that living and active spermatozoa were found in one seven days after castration, and in the other a month after the date of this operation. Obolonsky points out the fact that there is no reason for supposing that the same thing might not occur in a man; and em-

phasizes the importance of this possibility in a medico-legal sense.

It would be extremely interesting if this line of study were taken up and followed out by some American investigator, and an attempt were made to learn for how long a time after castration living spermatozoa could be detected in the seminal ducts or vesicles of animals; and also whether or not sexual excitation would cause their ejaculation. It is not likely that the results of such a study would prove of frequent applicability to actual medico-legal questions; but there is no telling when this very improbable occurrence might take place. Meanwhile, the matter would be of great physiological interest, and might throw a useful side light on other and commoner aspects of the phenomena of sexual intercourse and reproduction.

CATHETERIZING THE MALE URETERS.

One of the boldest suggestions in the line of surgical diagnosis which we have ever seen comes recently from Axel Iversen, of Copenhagen, who in the *Centralblatt für Chirurgie*, April 21, 1888, proposes the operation of supra-pubic cystotomy and catheterization of the ureters, as a means of determining which kidney of a man may be affected with pyelitis. In making this proposal, Iversen points out the importance of being able to ascertain which of the two kidneys is affected in any case, and the unreliability of the methods hitherto used for this purpose. In women it is not very difficult to catheterize the ureters through the urethra; but in men this is impossible. Last January Iversen had a patient with supposed calculous pyelitis, upon whom he thought it desirable to do a nephrectomy, or a nephrotomy. Being unable to ascertain in any other way which kidney was affected, he performed supra-pubic cystotomy, and catheterized both ureters. The result of this investigation showed him which kidney was affected with pyelitis, but it also satisfied him that no further operation was advisable, and he abandoned the idea of doing either a nephrectomy or a nephrotomy, as he had intended. The cystotomy wound healed satisfactorily, and the patient was none the worse for the diagnostic operation.

Iversen is so satisfied with the result obtained in this case that he declares that he would unhesitatingly repeat the procedure in a similar case, and expresses the opinion that supra-pubic cystotomy is by no means a dangerous operation, especially when performed for a diagnostic purpose.

There can be little doubt that supra-pubic cystotomy is an operation which, when carefully and skilfully performed, is not so dangerous as to preclude its employment for the purpose proposed by Iversen; and there seems to be sufficient justification for resorting to it when no other measure furnishes the information necessary to decide which of two kidneys shall be operated upon, when an operation on one seems to be necessary. As yet it has not been practiced often enough in this country to make it appear so simple an operation as it appears to Iversen; but its merits are understood well enough to prevent his conduct and recommendation from seeming to be rash.

QUACK ADVERTISEMENTS IN RELIGIOUS NEWSPAPERS.

It is pleasant to observe that our editorials in regard to the abuse of the columns of religious newspapers by the insertion of advertisements of quack medicines have not fallen to the ground without effect. From different parts of the country we have received communications which indicate not only that our comments have met with the approval of our professional brethren, but also that they have been taken to heart by some of those at whom they were directed. Among others, we note that the *California Christian Advocate*, a Methodist paper, endorses what we have said, and stigmatises quack advertisements in religious papers as an abomination. The editor adds that he rejects many advertisements, but that they are not usually submitted to him and he is not responsible for the business.

We regret that this should be the case; for we feel sure that if it were otherwise, the

paper which he edits would not illustrate the practice which he deplores. But, even as it is, we are glad to see in him an ally in a cause which we believe to be a worthy one, and which needs friends among the clergy. We have no doubt that there are many editors of religious papers who feel, with the editor of the *California Christian Advocate*, the mortification of having their names associated with papers which publish unblushing falsehoods, and we believe that if they wish they can soon end their troubles. Indeed we are sanguine enough to expect that they will do this, and to look to them with a good hope as well as good wishes.

Book Reviews.

[Any book reviewed in these columns may be obtained, upon receipt of price, from the office of the Reporter.]

DISEASES OF THE SKIN. A MANUAL FOR PRACTITIONERS AND STUDENTS. By W. Allan Jamieson, M.D., F.R.C.P.Ed., Extra Physician for Diseases of the Skin, Edinburgh Royal Infirmary, etc. With woodcut and eight colored illustrations. 8vo, pp. xiv, 546. Edinburgh: Young J. Pentland. Philadelphia: J. B. Lippincott Company, 1888. Price, $6.50.

This volume gives a clear exposition of the subject which it treats from an English standpoint. The author's ideas show the marked influence which the teachings of Hutchinson and Unna have had upon dermatology. The plan of the work is essentially that adopted in books of its class.

In regard to the natural oiling of the hair, the author considers that Liebreich's researches on lanolin lead to the conclusion that the hair itself secretes a cholesterin fat and is thus kept pliant. If this deduction is warrantable, it would raise the hair, as Jamieson states (and evidently accepts), to the position of a living structure, and the reported cases of sudden blanching, would not be necessarily either impossible or miraculous. The statement is made also, based evidently upon Unna's investigations, "that not only the papilla, but all the interior of the follicle, as far as the opening of the sebaceous gland duct, is capable of producing the hair." If this be confirmed it would, of course, have some bearing in the destruction of hair by electrolysis. In this operation a desideratum hitherto considered desirable has been the insulation of the end of the needle, so as to limit the electrolytic action to the papilla, and thus reduce the chances of scarring to a minimum; but according to the above view of the hair growth, such insulation, were it possible, would be a positive disadvantage. In describing the operation here referred to the author draws largely from the writings by G. H. Fox. The interrupter in the handle of the needle-holder, as suggested by Unna and here advised, is in our judgment not to be commended, being a disadvantage both to the operator and to the patient. When the current is thus broken there is always too much risk of disagreeable shocks, and these about the head are, it is needless to add, extremely unpleasant, and may in fact be even dangerous.

The name of "molluscum contagiosum" is retained, the author holding the common English view of its contagiousness. Herpes progenitalis is looked upon, in the majority of cases at least, as a sequela of some antecedent venereal disease, apparently through some persistent nerve irritability. This is in accord with Unna and Greenough—the correctness of the view we are, however, by no means willing to admit. To us a more rational explanation of its apparent frequency in those addicted to venereal pleasures is that in such individuals the slightest irritation about the genitalia excites solicitude, and a physician is consulted; whereas in those of correct habits this condition would probably give rise to no anxiety, passing away in a few days and thus escaping medical observation. In respect to Duhring's "dermatitis herpetiformis" the following appears: "Our acquaintance with cutaneous diseases will require to be more extensive and more precise before we can accept conclusions so sweeping as his; but the cases put on record are most valuable, and sooner or later will lead to more accurate knowledge." The colored illustrations, as is almost invariably the case in the text-books, are, in an artistic sense, poor, and do not add to the general excellence of the volume.

In the matter of therapeutics the author's views while sufficiently advanced are sound and conservative.

Correspondence.

Old and New Treatment of Pneumonia.

Editor Med. and Surg. Reporter:

Sir:—Acknowledging, with thanks, the notice in the Reporter of my recent paper on Pneumonia, allow me to say further to your readers that my purpose was not specially to advocate venesection, but to contrast the results of the now current method of treatment, which I characterize as stimulation and narcotism, with the practice of forty years ago, in which sedative and eliminative measures were used, among which local and, less often, general bloodletting has been proved to have positive value. My conclusion, based on observation and experience, and confirmed by statistics, is given as follows: "There is more room for question, on the basis of experience, between the treatment of forty years ago and pure expectancy, nursing the patient in bed without medication, than there is between the old practice and that which is now generally current." Yours truly,

H. Hartshorne.

Germantown, Philad'a.,
May 4, 1888.

Notes and Comments.

Fæcal Accumulation.

Dr. Julius Wesselowski, reports a case in the *Kansas City Med. Index*, March, 1888, in which a woman, forty years old, had been feeling bad for about two weeks. The patient had a peculiar ashy countenance, and a temperature of 103°; the tongue was coated, and the breath foul. She said her bowels moved every day, but not enough, although she had taken calomel, senna, jalap and salt. On examining her abdomen, he found it largely distended with gas and a very prominent lump in the right side of the body. After manipulating carefully, as even the slightest touch would produce indescribable pain, he made out a large accumulation of fæcal matter in the ascending colon. He injected into the bowel at first two ounces of glycerine every hour, and gave an injection of soap and water every hour. After six hours of hard work, he noticed that the lump, by easy manipulation, became softer and friable. The first good movement the patient had was in about seven hours after his arrival. As soon as she had a movement, which consisted of hard lumps containing graham flour and raspberry seeds, which she had eaten about two weeks before, she became easier. The gas passed off, and the temperature fell to 99°. The next day he learned that she had about six more movements during the night and morning. He examined her again at that time and found that the whole lump had disappeared. In a few days she was well. He advises never to give a purgative of any kind while the fæcal impaction exists.

Cocaine and Loss of Vitreous in Cataract Operations.

Dr. A. D. Williams says: As I have heretofore stated, the greatest benefit we get from the use of cocaine in operating on cataracts is the almost entire prevention of the loss of vitreous. Before the introduction of cocaine the greatest anxiety in cataract operations was the ever-present fear of rupture of the hyaloid membrane and loss of vitreous. Cocaine prevents this accident in an indirect way. It kills sensibility, and thus prevents all muscular action. In this way the patient is prevented from *squeezing* the vitreous out by violent muscular contraction. While killing the pain of the operation is a grand thing, the resulting or secondary effect is the greatest boon. Since using cocaine the loss of vitreous has been the rarest exception. Only very recently I operated on an old man in the usual way. The lens was easily delivered. In manipulating the cornea for the purpose of clearing the anterior chamber of all particles of lens substance, suddenly and unexpectedly a bead of vitreous popped up. I had to desist to allow the remains of the lens to be absorbed away. Had there been no cocaine used in this case the loss of vitreous would certainly have been "frightful," and very likely destructive. The patient made a rapid recovery and had a good result. This, so far as I remember, is the first loss of vitreous I have had since using cocaine.—*St. Louis Med. and Surg. Journal*, April, 1888.

Remarkable Tolerance of Bullet Wound of the Brain.

It is reported in the Philadelphia *Ledger*, April 21, from Owingsville, Ky., that a man named A. G. Owings, who had been shot on the 7th inst., died on Thursday from the effect of that wound. The ball from a 38-calibre pistol struck Owings in the forehead between the eyes, and penetrated to a depth of five inches. Owings felt so little inconvenience that, thinking the ball was only below the skin, he did not send for the doctor to remove it until the following Monday. In probing, the doctor extracted about a spoonful of brain, but did not find the ball. Still Owings felt but little pain, ate and slept as usual, and attended to his work until the morning of the day he died. He then, after a deep sleep, sank into a stupor, in which he died.

Formula for Migraine.

Dujardin-Beaumetz recommends:

Tincture of gelsemium.....fʒiij ¼
Simple syrup.....fʒviij

M. S. Dose—One tablespoonful three or four times a day.

Hydrofluoric Acid in Phthisis.

At glass factories the beneficial influence of hydrofluoric acid on tuberculous workmen has long been noted, and many attempts have been made to employ this agent in the regular treatment of phthisis. M. Garcin has cured thirty-five and relieved thirty cases out of a hundred by means of this acid; ten of the hundred died, and in fourteen there was no improvement. The patients sit for one hour a day in an atmosphere saturated with hydrofluoric acid. This saturation is effected by passing a current of air by means of a pump through a tank of gutta-percha containing nine and one-half ounces of distilled water, and three-fourth ounces of hydrofluoric acid —*Lancet*, February 4, 1888.

Abscess in Bulbous Portion of Urethra Following Gonorrhœa.

At the meeting of the Sacramento Society for Medical Improvement, Feb. 21, 1888, Dr. G. L. Simmons, Jr., reported a case in which an abscess in the urethra had formed four weeks after the appearance of the discharge. The patient, a young man, had used one of the many patent injections, and with entire success as he supposed, until he noticed a swelling just under the pubic arch. The discharge at that time had almost ceased. This swelling, which was accompanied by severe pain andfever, compelled him to seek medical aid. The injection was stopped, cold applications to the perineum ordered, and an antipyretic internally. An anodyne suppository was found necessary to control the pain at night. Though the acute symptoms moderated the swelling increased until the entire penis became three times its natural size, congested and resistant along its entire length, and the foreskin, which was naturally quite redundant, was painfully distended. Micturition was difficult. The least chordee was insufferable to the patient, and the strength of the anodyne was doubled to counteract the pain. Poultices, as hot as could be borne, were applied, when it became certain that the formation of pus could not be arrested. Under this local treatment, with quinine and iron internally, and opium by the rectum, the abscess broke on the tenth day. The opening was evidently in the bulbous portion of the urethra, as there were no symptoms connected with the neck of the bladder. The purulent discharge was quite free. The patient's general health continued remarkably good throughout the whole course of the abscess formation, and with the evacuation of the pus all the minor symptoms disappeared. At no time was there any vesical irritation or prostatic trouble. Under a mild injection, the gonorrheal symptoms which had again declared themselves, readily yielded. At the date of this report, one month from the time of the rupture of the abscess, Dr. Simmons says that there remains an infiltration about the bulbous portion of the urethra, which causes the penis to be somewhat bowed during vigorous erection. With this single exception his condition is perfect.—*Sacramento Med. Times*, April, 1888.

Pathogeny of Iodoform Delirium.

At the meeting of the Academy of Medicine of Paris, March 20, M. Jeannel made an interesting communication on the "Pathogeny of Iodoform Delirium." The application of iodoform produces, he says, unimportant or serious effects according to the state of the patients. Each time delirium has occurred in a wounded person treated with iodoform, M. Jeannel proved that the patient had suffered from an antecedent cerebral affection, either alcoholism, chronic meningitis or mental derangement. His observation enabled him to conclude that, (1) a wound on an individual not suffering from a constitutional infirmity, may be dressed with iodoform; (2) this may also be done if the patient be not suffering from a constitutional affection not cerebral; (3) iodoform applied to a wound on a patient affected with a cerebral constitutional malady, produces delirium of greater or less intensity.

Galezowski's Antineuralgic Formula.

The Paris correspondent of the *Pharmaceutical Record*, gives the following formula:

Menthol.....gr. xij
Cocaine.....gr. iv
Chloral.....gr. ij
Vaseline.....gr. lxxv

M. Ft. Unguentum. Sig.—Apply to the painful parts, and cover with muslin.

It is said to be especially useful in perior bital pains and in ophthalmic hemicrania.

Medical Society of the State of New Jersey.

The one hundred and twenty-second annual meeting of the Medical Society of the State of New Jersey will be held in the Heath House, Schooley's Mountain, on Tuesday and Wednesday, June 12 and 13. Treasurers of District Societies are requested to send the amount of dues of their respective Societies to Dr. W. W. L. Phillips, Trenton, on or before June 11. Abundant space has been provided for exhibitors of surgical instruments. There will be a complimentary banquet in the Heath House, Tuesday evening at 10 o'clock, to the delegates and visitors. Dr. John G. Ryerson, Boonton, N. J., is Chairman of the Committee of Arrangements. A very interesting series of papers and discussions is on the programme.

Celebration in Honor of Dr. Hiram Corson.

Dr. Hiram Corson, of Conshohocken, Pa., was given a complimentary banquet, April 25, by the Montgomery County Medical Society, in honor of his sixtieth anniversary in the active practice of medicine. Dr. J. K. Weaver presided. A number of distinguished physicians from all parts of the State were present. After the banquet and some preliminary remarks by Dr. Weaver, the latter called upon Dr. P. Y. Eisenberg to

respond to the toast "Our Honored Guest." In the course of his address he referred especially to the debt which the profession owed Dr. Corson for his advocacy of the treatment of inflammatory diseases and acute infectious diseases with cold.

In Dr. Corson's reply he referred to the early days of his career, and to the many men of mark of a former generation whom he had known. .Speaking of the country as it was in his earlier days, and of the methods of travel, he said:

"To me, then a mere stripling, there was at the time of which I speak no Ardmore, no Bryn Mawr in Lower Merion, no Bridgport in Upper Merion, no Collegeville, Zieglersville or Pennsburg on the banks of the Perkiomen, no Lansdale or North Wales, no Fort Washington or Ambler on the Wissahickon; and, above all, no Conshohocken, East and West, with their thousands of people. Norristown was a mere village, noted only for its small academy, its court-house and prison, and its two-horse stage which made daily trips to Philadelphia. Then the postage on a letter in Pennsylvania was 10 cents, but if it were to be sent "away off" to Ohio, twenty-five cents was demanded. There was scarcely a bridge, save on the turnpike roads, over the rapid and oft-times swollen Skippack, Perkiomen and Wissahickon creeks, and even the Schuylkill river had to be passed through the water at its various fords, by the physicians in their rides by night as well as by day, and often at the risk of life. Dr. McLean, who practiced in Horsham earlier than the persons already named, was drowned while fording the Wissahickon below Reiffs mill. Physicians generally rode on horseback. For years I crossed the Schuylkill river at Matson's Ford—the present site of Conshohocken bridge—oft-times when the cold, almost freezing water came far up the horse's sides. Patients were widely separated and physicians were rarely able to see even their acute cases oftener than every other day. Consultations were rare. However fiercely death assaulted, we were compelled to confront him alone. Sorely did I feel this necessity, and how great was my relief when I could have the counsel of an experienced physician! In this isolated way, we worked along for many years."

On January 17, 1847, the Montgomery County Medical Society was permanently organized, and owes its present success largely to the untiring energy and zeal of Dr. Corson.

Following Dr. Corson's reply, there were a number of short speeches by the different physicians who were present.

NEWS.

—Dr. Joseph Bauer has been appointed Professor of Clinical Medicine in the University of Munich.

—Dr. C. S. Muscroft, of Cincinnati, died suddenly in that city, May 5. He was at one time President of the Cincinnati Academy of Medicine.

—Dr. Straus has been appointed successor to the late Prof. Vulpian as Professor of Experimental and Comparative Pathology in the Faculty of Medicine of Paris.

—Dr. C. D. Palmer, of Cincinnati, was seriously injured, May 6, by being thrown from his carriage while his horse was running away. It is feared that his injuries may prove fatal.

—The prize offered by the *Pharmaceutical Era* for the best essay upon the Mutual Relations of Physicians and Pharmacists, has been awarded to Prof. F. H. Gerrish, of Bowdoin College.

—In the *Boston Med. and Surg. Journal*, May 3, 1888, Dr. John Homans reports a case of ovariotomy for multilocular papilloma in a woman eighty-two years and four months old. He states that not a single case of ovariotomy in women eighty years of age or older had been previously reported. His patient recovered.

—The Camden County Medical Society held its annual meeting at Gloucester City, May 8, Dr. Gross presiding. Officers were elected as follows: President, W. H. Iszard; Secretary, E. L. B. Godfrey; Treasurer, A. M. Mecray; Board of Censors, Drs. John W. Snowden, H. G. Taylor, J. R. Stevenson, Alexander Marcey and H. E. Brannon. Delegates were also elected to the various conventions and national associations. At the dinner which followed, Dr. H. Genet Taylor was presented with a silver set as a testimonial of services of a quarter of a century as Secretary.

—A bill has been introduced into the Legislature of New York which provides that "it shall not be lawful for any person or persons to introduce into or upon any dead body of any person or human being any poisonous substance, organic or inorganic, for the preservation of the same, or any so-called embalming fluids or materials of any kind, which will, in any manner whatsoever, interfere with chemical tests which may subsequently be applied or made use of by chemists in medico-legal investigations."

HUMOR.

ETHEL USED TO PLAY A GOOD DEAL in the school class. One day she had been very quiet. She sat up prim, and behaved so nicely, that after the recitation was over the teacher remarked: "Ethel, my dear, you were a very good little girl to-day." "Yes'm. I couldn't help being dood. I dot a tiff neck."—*Presbyterian Banner.*

A REMARKABLE CASE OF HEREDITY.—A correspondent of the *N. Y. Medical Journal*, April 28, 1888, writes that a hydrocephalic child was born to an ultra-prohibitionist father, who said to the doctor:

"What is the matter with my child?"

"Why, it has inherited its disease from you."

"What do you mean?"

"Why, it has *water on the brain.*"

THE *Ft. Wayne Medical Journal* indulges in the following anent microbes:

Some M. D.'s are downright skeptics,
Devoid of faith in antiseptics,
The very name of microbe hate,
The chief of whom is Lawson Tate.

To this the *Medical Standard* adds: This is the most severe cut Tait has had to endure; nobody previously had ventured to insinuate that he was a microbe.

NEW DRUG CLERK—"Beg pardon, sir, but that young lady who just went out asked you for infant powder." Old druggist—"Yes," "But you gave her regular face powder." "Yes; I always make that mistake. That's how I got up such a big trade. If a woman really wants infant powder she will insist upon having it."—*American Hebrew.*

Official List of Changes of Stations and Duties of Medical Officers of the U. S. Marine Hsopital Service, for the two weeks ended May 5, 1888:

P. H. Bailhache, Surgeon, to proceed to New York, N. Y., for temporary duty, May 1, 1888.

W. H. H. Hutton, Surgeon, detailed as President of Board to report as to quarantine establishment at North Chandeleur Island, Gulf of Mexico, May 4, 1888.

Walter Wyman, Surgeon, granted leave of absence for fourteen days, May 4, 1888.

G. W. Stoner, Surgeon, detailed as Chairman of Board for the physical examination of candidates for appointment and promotion, Revenue Marine Service, May 5, 1888.

F. W. Mead, Passed Assistant Surgeon, detailed as Recorder of Board for the physical examination of candidates for appointment and promotion, Revenue Marine Service, May 4, 1888.

H. R. Carter, Passed Assistant Surgeon, detailed as Recorder of Board to report as to quarantine establishment at North Chandeleur Island, Gulf of Mexico, May 4, 1888.

S. C. Deevan, Passed Assistant Surgeon, relieved from duty at Sapelo Quarantine; to assume charge of the service at Savannah, Ga., May 3, 1888.

J. H. White, Passed Assistant Surgeon, relieved from duty at Savannah, Ga.; to assume charge of Sapelo Quarantine Station, May 3, 1888.

Official list of changes in the Stations and Duties of Officers serving in the Medical Department, U. S. Army, from May 6, 1888, to May 12, 1888:

Lieutenant-Colonel James C. McKee, Surgeon, granted leave of absence for one month. S. O. 107, A. G. O., May 9, 1888.

Major Charles R. Greenleaf, Surgeon; Major Robert M. O'Reilly, Surgeon, and Capt. John O. Skinner, Assistant Surgeon, detailed as members of a board of medical officers to assemble at the U. S. Military Academy, West Point, N. Y., on June 1, 1888, to examine into the physical qualifications of members of the graduating class and of the candidates for admission to the Academy. S. O. 104, A. G. O., May 5, 1888.

Par. 11, S. O. 104, A. G. O., May 5, is amended by Par. 4, S. O. 108, A. G. O., May 10, 1888.

Major Charles R. Greenleaf, Surgeon; Major Robert M. O'Reilly, Surgeon, and Capt. John O. Skinner, Assistant Surgeon, are detailed as a board of medical officers to assemble at the U. S. Military Academy, West Point, N. Y., on June 1, 1888, to examine into the physical qualifications of the candidates for admission to the Academy, and, in connection with the Superintendent of the Academy and Commandent of Cadets, the members of the graduating class.

Major Harvey E. Brown, Surgeon, the leave of absence for seven days granted by orders 68, Fort Barrancas, Fla., May 2, 1888, is extended twelve days. S. O. 90, Div. Atlantic, May 8, 1888.

Capt. Leonard Y. Loring, Assistant Surgeon, granted leave of absence for three months on surgeon's certificate of disability. S. O. 105, A. G. O., May 7, 1888.

Capt. Paul R. Brown, Assistant Surgeon, granted leave of absence for six months, on surgeon's certificate of disability, with permission to leave the Division of the Atlantic. S. O. 107, A. G. O., May 9, 1888.

Capt. Robert B. Benham, Assistant Surgeon, to proceed from Du Chesne to Fort Douglas, Utah, and report to commanding officer of that post, not later than 25th inst., to accompany Battalion of 6th Infantry to Fort Lewis, Col. Upon completion of this duty, will return to his station, Fort Du Chesne, Utah. S. O. 33, Dept. Platte, May 5, 1888.

Changes in the Medical Corps of the U. S. Navy for the week ending May 12, 1888:

Passed Assistant Surgeon A. G. Cabell, detached from "Adams," and to proceed home and wait orders.

Surgeon M. H. Simons, detached from Naval Academy, and to Practice Ship "Constellation."

Medical Director P. J. Horwitz, leave of absence for six months to leave the United States.

A Naval Medical Examining Board is now in session at the Naval Hospital, Philadelphia, for the examination of candidates for admission to the Medical Corps of the Navy. There are eleven vacancies in the list of Assistant Surgeons. Permits for examination can be obtained on application to the Secretary of the Navy.

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Communications.

ON THE TREATMENT OF CHRONIC DISEASES OF THE HEART.[1]

BY PROFESSOR M. J. OERTEL,

MUNICH, BAVARIA.

The pathological alterations of the heart muscle may pertain either to quantity or quality. The quantitative alterations have to do with either augmentation or diminution of the muscular mass of the heart. They affect either certain parts of the heart, or the entire organ. The augmentation of the muscular mass—*hypertrophy* of the heart—is rarely a primary affection. Almost always it is the consequence of obstacles in the blood current, and is due directly to overwork imposed on the heart by these obstacles. It is then a compensatory hypertrophy, a necessary hypertrophy, and as such it will not do to combat it; it will not do to think of reducing the size of the heart under such circumstances. On the contrary, this compensatory enlargement when it exists is to be respected and kept intact, and we should endeavor to reproduce it when it is enfeebled or lost.

Diminution of the muscular mass—*atrophy* of the heart—when it affects the entire organ, accompanies general disturbances of the nutrition; it is associated with a diminution of the quantity of the blood. Partial atrophy leads to dilatation of the thinned cardiac walls. The *qualitative* alterations of the heart muscle follow disorders of nutrition or processes of degeneration. The muscular fibre itself is diseased, it performs its functions badly, or it is destroyed. The gravest form is that in which the muscular fibre is destroyed by fatty degeneration, the result of prolonged super-alimentation, of marasmus, or of chronic alcoholism.

The character of chronic affections of the heart is always the same; we observe always a diminution of the cardiac vigor going on to insufficiency, and the symptoms are constantly those of troubles of the circulation: arterial anæmia, venous stasis, augmentation of water in the blood and in the tissues, consecutive renal affections, dropsy, paralysis of the heart. Consequently, the ends to attain by treatment are the following:

1. To make the heart sufficient for its tasks; to re-establish its vigor; to augment the muscular mass of the organ till a compensatory hypertrophy is obtained, which, at the same time, shall remedy any partial existing dilatation.

2. To regulate the disturbed blood current, as well as to restore the altered constitution of the blood.

The prognosis will depend on the nature and degree of the troubles of nutrition, and on the existence of complications.

Before taking up the dietico-mechanical treatment based on these principles, it will be worth while to glance over the history of the treatment of cardiac affections.

Albertini and Valsalva fully believed in the possibility of exercising a direct influence on the heart, notably on the hypertrophied and dilated heart. They ordered absolute rest, and a very severe debilitating regimen; blood lettings, frequently repeated—as often as the pulse became stronger; food reduced to the minimum, nothing more than a little broth several times a day being allowed. Laennec employed a similar treatment, but he applied it only to patients not yet cachectic

[1] A paper read before the Seventh Congress of Internal Medicine, held at Wiesbaden, April 10, 1888. [Prepared from Dr. Loewenthal's report (*Semaine Médicale*), by E. P. Hurd, M.D.]

or dropsical. I think it useless to attempt to show the folly of such treatment.

Later, the treatment became rather expectant and a careful attention to symptoms, but the blood lettings were continued. Absolute rest in bed was abandoned in favor of limited corporal exercises. With the exception of the blood lettings, this treatment has remained in force down to our own day.

Wunderlich began a reform by changing the indications of treatment. Along with the symptom treatment of the cardiac affection, he believed in the necessity of restoring the harmony between the vigor of the heart's contraction and the quantity of blood to be put in circulation. Only, he attempted to accomplish this by diminishing the quantity of the blood, and this is why he still prescribed blood-letting. Starting from a correct principle, he ended in an erroneous therapeutic result.

Stokes was the first to dare to attack the principle of absolute rest. He recommended physical exercises, which were to be gradually and systematically increased; journeys on foot in mountainous countries, as Switzerland and Scotland. As for diet, he prescribed substantial food, a great deal of meat, and but little fat. Despite their importance, Stokes's principles did not awaken attention; they were neglected in practice and in scientific studies. With the exception of the fact that they called forth angry protests in England and elsewhere, his propositions were simply ignored. Practitioners continued to insist on the necessity of sparing what remained of the heart's forces by prolonged rest, and of preventing an increase of fat by Banting's system.

It was during the almost absolute prevalence of these principles that I dared in 1875 to raise my voice in favor of endeavors to exercise a direct influence on the heart suffering from insufficiency, and restore lost compensation. I think that I have succeeded. The principles which have guided me are the following: To remove, by an appropriate diet, the troubles of nutrition; to improve the quality of the blood; to reduce the redundancy of water in the economy to its normal amount; to facilitate the encumbered work of the heart; to fortify the heart muscle in the direction of an augmentation of its volume; to raise the pressure in the arterial system; to regulate the exchange between the arterial and venous system; to unburden and relieve the kidneys; lastly, to maintain the re-established vigor of the heart by a reasonable dietary, and by gymnastics and other exercises, notably by mountain climbing. So then my treatment divides itself into two parts, the regimen and the mechanical part. These two parts are complementary to each other; there are very few cases in which the one is indicated without the other.

As for the matter of regimen, my method necessarily takes account, on the one hand of the general state of nutrition, and on the other, of the quantity of liquid accumulated in the vessels and tissues of the body.

Relatively to the general state of the nutrition, especially to the quantity of fat, we have to establish the following distinctions:

1. Much fat with plethora: the heart enfeeblement is but just commencing. The appropriate regimen will comprehend an increase of albumen in the food and a diminution of fatty substances, or substances which produce fat; little or no diminution of liquids.

2. Polysarcia, with serous plethora: augmentation of albumen, diminution in fatty substances and liquids.

3. Lipomatosis cordis, with hydræmia in aged persons; the albumen and fat of the body tend to diminish. Here you want to augment the ingestion of albumen. Continue and even *augment* the ingestion of fatty substances, and diminish liquids.

As for the mechanical part of the treatment, these are the principles:

In order that you may cause a muscle to become hypertrophied, it is not enough to augment the introduction of albumen into the economy, you must also augment the function of the muscle. This physiological principle, which is true for all the muscles, is no less true for the heart muscle. We should, then, endeavor to augment both the number and the force of the heart's contractures. We may arrive at this result by different means. Every muscular contraction, it matters not in what part of the body, influences equally the heart, arouses its contractions, and augments their number and force.

[Prof. Oertel here presented an instructive table showing the normal "hyperplasia" of the heart in animals subjected to much exercise, as cattle, horses, hares and deer, and the ratio of the heart to the body in such animals. This is contrasted with the ratio in men and animals given to rest rather than exercise. The working heart is larger, thicker and heavier, as might have been expected, and its ratio to the bodily weight, as a rule, is greater.]

Let us now glance at the phenomena witnessed in man after prolonged exercise in making ascensions. From these phenomena

we draw conclusions, establishing the fact of a higher nutrition, and an actual hyperplasia of the muscular fibres of the heart:

1. All the arteries dilate, and the blood pressure increases in the arterial system.

2. The contractions of the heart become stronger.

In gauging the work imposed on the muscles by the ascension of different heights with a scale varying from 1 to 20 degrees, and in more or less prolonging these tasks, adding to their duration as the strength may bear, we may graduate the influence exercised on the cardiac muscle, and adapt the treatment to each special case. The application of these principles has been made in the *land-cure stations* (Terrain-Kurorte) with which you are acquainted. Simple gymnastics and Swedish gymnastics, prescribed and applied with or without medicinal baths, also exercise undoubtedly a great influence upon the heart; but hill-climbing and mountain-climbing seem to me the most appropriate, calling into play as no other exercise does, the respiratory forces, and imposing on the patient a course of pulmonary gymnastics which enlarges the reservoir indispensable to the circulation of the blood in the lungs. Lastly, ascension-excercises put in movement the muscles of the lower extremities, force the venous blood from its favorite haunts of stasis, and thus directly combat the venous congestions, so sure to accompany cardiac failure.

To fortify the heart is not enough; we must also, as I have before said, diminish the work of blood-conveyance imposed upon the heart. Wunderlich has counselled to attain this result by reducing the total quantity of blood. I believe, however, that we may accomplish the same end by diminishing as much as possible the aqueous contents of the whole body without meddling with the albuminous contents of the blood. I attempt to bring this about by the following means:

1. By diminishing the quantity of liquids introduced into the organism with the food; this point I have alluded to before, while on the dietetic regimen.

2. By augmenting the secretions. The exercise of mountain-climbing augments the excretion of water, both by the enhanced work of all the muscles (elimination by the skin), and by the increased vigor and quickness of the respiratory movements. It is clear that the evaporation of water from the surface of the lungs must increase correlatively with the intensity of the respiration. The elimination by the skin may be also augmented by heat under all its forms: sun-baths, sand-baths, vapor-baths, warm-water-baths, etc. The diminution of liquids introduced into the organism along with the food is of itself attended with augmentation of the urinary secretion when the kidneys still perform their functions normally.

It must be obvious that a method which has so energetic an action on the heart and the entire circulatory apparatus, must sometimes encounter insurmountable obstacles to its application. It is clear, then, that great precaution is necessary in the application of this system to individual cases, and that no iron rule can adapt itself to all; the general principles of treatment, however, I believe to be sound.

In conclusion, the results which have been obtained by my system in places in which the "land-cure" method has been carried out according to my directions, have been satisfactory. I have received special reports from the following stations: *Ueran*, *Ischl*, *Reichenhall*, *Liebenstein*, *Baden-Baden*, *Abazzia*, *Kreuth*, and *Wilbad*.

These results have been as follows:

1. Exclusively favorable in cases of fatty heart — even when pronounced — without sclerosis of the coronary arteries, but with serous plethora, venous stasis, and often œdema. The patients were for the most part aged. The following consequences have been noted: The vigor of the heart returns, the heart-impulse and its sounds become more audible, the pulse, before irregular, becomes regular, the albuminous capital of the body augments, the fat diminishes, and often in a marked manner.

2. Augmentation of the muscular mass of the heart, even to the establishment of a compensatory hypertrophy: this has been especially apparent in valvular affections of the left ventricle, and where the pulmonary circulation has been embarrassed by affections of the dorsal spinal cord.

3. Disappearance of very marked dilatations when the primary affection (insufficiency or stenosis of the valves) is not of too long standing.

4. Restoration of the harmony between the arterial and venous circulation, augmentation of the quantity of blood and of blood pressure in the arterial system, diminution of the cyanosis, of the serous plethora and of the effusions, when the latter already exist.

5. Diminution and disappearance of the respiratory troubles.

Finally, these results seem lasting; they have persisted for years (in some cases from nine to twelve years), which proves that we have not had to do here with that spontan-

eous amelioration which sometimes supervenes without any treatment to disappear shortly afterwards, but with a real and permanent amelioration of this state of the heart muscle.

QUADRUPLE AMPUTATION; RECOVERY.

BY G. C. WALLACE, M.D.,
ROCK RAPIDS, IOWA.

In the REPORTER of April 7, appears a report of a case of simultaneous triple amputation performed by Prof. Ashhurst, in which I notice the statement that he has been able to find but one instance of quadruple synchronous amputation, and as it may be of interest to the readers of the REPORTER I send a report of a quadruple synchronous amputation which I performed the 27th of last January, together with a brief history of the case.

The patient was a German, sixteen years of age, weighing about one hundred and sixty pounds. He was frozen the night of January 12. Being at school on the 12th, he started home as usual, and was overtaken by the noted January blizzard. He lost his way and was out all night, and was picked up for dead the next morning, but noticing him make a slight noise, the men who found him took him to a school-house, about a mile distant, and there commenced trying to revive him by rubbing and applying kerosene oil. I was immediately sent for, but owing to the severity of the storm could not reach him until the morning of the 14th, when I found him in a semi-comatose condition, but entirely thawed out. I gave him some whiskey and quinine, and applied tincture of iodine and a solution of carbolic acid. In about forty-eight hours I had him taken home, and let him lie until January 27, giving him meanwhile elix. pyrophos. iron, quinine and strychnine, and applied part of a mixture of ung. petrol. ℥x, hydrastin ℥iv, ac. carbolic. ℥ij, once daily. On the 27th, I took off both arms about half-way between elbow and wrist, and the right leg about three inches above the ankle-joint, and the left foot through the first row of tarsal bones, leaving three of them, and cut off the heel, leaving the os calcis exposed for over one inch. The flesh was putrid, but I found the bone uninjured, and so left it for the flesh to grow on again (which it has now done). I operated on all the limbs before dressing any of them or taking up any arteries; I next took off the point of his nose. After operating, I used hyd. chl. cor. ℥iv, spt. vini rect. ℥iv; one teaspoonful of the mixture to one pint of tepid water, and washed each stump with this solution. Next I saturated some absorbent cotton with the same solution and applied it over each stump, covering this with oil silk.

I continued giving the elix. pyrophos. iron, quinine and strychnine, and discharged him on March 18, when the wounds were all healed up, except one place about as large as a dime; and at the present time he has gained several pounds in weight and claims that he feels as well as usual.

If any one knows of any other operation of the same kind I would be pleased to hear from him, and if any surgeon wishes to know anything further in regard to this case I will cheerfully furnish any information desired.

AN INTERESTING OBSTETRICAL CASE, WITH PECULIAR ANOMALIES OF THE CHILD.

BY T. L. TAYLOR, M.D.,
OF LISBON, DAKOTA.

Mrs. W., 25 years old, was taken in labor at her second confinement, about six o'clock A.M, April 20, 1888. The labor pains continued at regular intervals. I was called about 3 P.M. the same day, and found the bag of waters protruding through the os, which was dilated to the size of a silver dollar. I ruptured the membranes and the liquor amnii that escaped was of a greenish color and of a very offensive odor, and of the consistency of glycerine. I diagnosticated a breech presentation, and as labor progressed rapidly I brought down the feet and had the body delivered in a few moments. Now appeared the trouble. I noticed a deformity of the legs, feet, and the back at this time, and owing to the apparent inability to deliver the head I concluded that I had to deal with a case of hydrocephalus—which proved true. I inserted the first two fingers of my right hand into the vagina, and got them into the mouth of the child and flexed the chin, thus gaining quite a little ground. The patient then asked me to wait a few moments and she would summon all her strength and courage to help me; so when another pain came on, by our united efforts she was delivered of a male child without the use of any instruments, and without any laceration of the mother. I invited two of the medical men of our city to go over and see the child (which was still-born) the same evening, and

the following notes were taken: The length of child was 22 inches; its weight 11 pounds; the measurement from the occipital protruberance to the forehead was 12¾ inches; and from the former point to the chin was 14¾ inches; the measurement from temple to temple over the top of the head was 11¾ inches; the circumference of the head was 18 inches; the length of umbilical cord was 42 inches. The face was well formed, eyes, nose, ears and mouth were all in a normal condition. There did not appear to be any neck to the child, the head seemed as though set upon the shoulders. At the junction of the dorsal and lumbar vertebræ the spine bifurcated; at this point can be seen two distinct sets of spinous processes which extend to the pelvis. A sac containing about two ounces of serous fluid (hydrorachis) was attached to the back over the two spines. There was no deformity of the anus, but there was epispadias of the penis. The legs were deformed. There was talipes equino-varus of the left foot, and of the right foot talipes varus only. One half of the placenta was made up of small hydatiform vesicles containing a reddish fluid, and having the appearance of a bunch of grapes, while the other half was to all appearance normal. The cord was found wound around the body twice and around the neck twice. The patient has always been in a healthy condition in every respect; there has been nothing of specific origin in her or her husband's history. She tells me now that for the past three months at different times, although she has felt well, she has passed by the vagina pieces half the size of her hand, which looked like pieces of spoiled meat and had a very offensive odor. This is the second case of hydrocephalus I have had out of four hundred and ninety-six cases of labor at full term; both were in male children, both were still-born, and both mothers are living and well.

PROSTITUTION.

BY JANET E. RUNTZ REES.

Prostitution is generally looked upon as a necessary evil. The class of so-called "unfortunates" in every great city increases in direct proportion to its prosperous conditions, and, whether under special legislative control or not, exercises indirectly a terrible influence upon its social life. Those who are most forward in their efforts at rescuing the fallen and degenerate women, who are the offscourings of civilized communities, rarely look beyond the surface of the subject with which they are dealing, or, if they do, it is either with sentimental or religious horror at the impurity and loathsome details which are necessary accompaniments of missionary effort in this direction. Appeals are constantly made to public opinion or public sympathy in regard to the possible reclamation of fallen women, and the subject has so long been regarded from this standpoint that the question of "fallen" man has never yet, so far as I am aware, been discussed at all. It is to my mind of even greater importance than the terrible subject of diseased and prostituted womanhood, for the reason, that while the desecration of the one sex is directly traceable to the inflamed passions of the other, it seems impossible to ascertain how far sexual gratification is essential to robust manhood.

The institution of marriage would in itself appear to indicate the necessity of sexual intercourse for both men and women, for that, however, we may regard it, is the mainspring of conjugal relationship. If it were eliminated as a factor in married life, and the possibilities of intercourse between the sexes limited to the ordinary demands of friendship, if coition in itself were not a principal object of marriage, apart even from procreation, we could better understand upon what ground prostitution should be judged, and whether it should be condemned as sexual intemperance or indulgence only, or on account of the terrible results which ensue from it. We should better understand, in short, what *constitutes prostitution*, and in what sense licensed intercourse is better than unlicensed intercourse. As regards the moral question, as much contempt is expressed socially for the young woman who has, as it is said, fallen and lost her virtue for the sake of love, as for the shameless denizen of a public thoroughfare. This fact in itself is a prolific source of evil, for the ranks of the unhappy women whose charms are purchasable are recruited by those whose crime has often been the mere acceptance of a lover's caresses. If sexual intercourse before marriage is a crime for the woman, punishable, if *discovered*, by shame and contempt, involving the illegitimacy of offspring and life-long isolation for the mother, why is it at once not only justifiable, but an *absolute virtue* directly, the marriage knot is tied? The woman who *after* marriage repudiates sexual claims is blamed, while the girl, who in ignorant response to an indefinite longing, or in the excitement of incipient passion, hallowed by love, but not by law,

listens to the selfish reasonings of a promised husband, is held to be equally in fault, and far more heavily punished.

The *morality* of sexual intercourse is in itself a subject well worthy of consideration. Is it or is it not dependent upon marriage? And if it is, what excuse can be found for the men who, consider it in what light we may, are responsible for the existence of fallen women? If our cities and towns swarm with diseased women; if our village statistics show the births of hundreds of children owned by no father; if our insane asylums number among their inmates dozens of young girls and older women, distraught from loss of virtue, who but men have been the agents of these destructive elements? And if from the moral side of this terrible question we turn to the physical, what do we find? Unmarried girls paying the penalty of life-long suffering for the momentary gratification of a lover's lust; married women, dying by inches, because violated nature refuses to respond to the constant demands of rampant passion. This aspect of the question is a very terrible one. It is *in itself* one, and a very prolific source of prostitution. Statistics have proved that the men who frequent brothels and who support mistresses are more often than not married men. On the other hand, married women are often unfaithful, demanding more in sexual gratification than the husband is disposed to give, or simply obedient to that diseased appetite which is one result of a constant solicitation on the husband's part.

If society has ordained distinct codes of morality for men and women, nature has not. The physical punishment of an unchaste life visits the man almost equally with the woman, in premature decadence; and the woman who has fallen from virtue for the sake of the man, becomes in her turn the vehicle of disease to his fellow-man. How find a remedy for an evil so far-reaching, so imperative in its consequences? There would appear to be but one way, and that not a popular one, viz., by a consideration of prostitution upon its own merits or demerits, apart from social or family views of it—a consideration of its *fundamental* lawlessness on the part of man as well as woman, which must begin with a preliminary inquiry into its origin, growth and present potency. How far, in a word, is prostitution or unlicensed intercourse in itself a breach of nature's law, and as such punishable by suffering, disease and premature decay? And how far is it merely a social evil, to be regulated by law or by public opinion? What part does coition play in nature's plan? What justification exists for the prominent part it assumes in the lives of individuals? How can we best meet and overcome, or better still, obviate the results of sexual appetite, as shown in the unbridled indulgence of unlawful passion, or its scarcely less hurtful influence in legalized unions? This is a question of importance to every one, but, above all, to the medical profession.

CASE OF RADICAL CURE OF HERNIA.

BY A. ADY, M.D.,
MUSCATINE, IOWA.

I was called January 19, 1888, to see C. B., 59 years old, a farmer, who was suffering with a strangulated direct inguinal hernia of the right side, which I succeeded in reducing by taxis, but with difficulty. The patient was an old soldier who had suffered from chronic diarrhœa since 1863. He was partially paralyzed on the right side; complained of palpitation, and in addition his feet were swollen and both lungs emphysematous. His urine was found to be albuminous; and the microscope revealed hyaline and granular casts. I fitted him with a Hubbard truss, but he would not wear it next to the skin, and of course it was not effective.

On February 2, he came to my office with his hernia out again, and was unable to return it; I reduced it by taxis, but with greater difficulty than before. He returned again on the 25th in the same condition, and this time he was suffering pain. A hypodermic injection of half a grain of morphia and one-sixtieth grain of atropia was given him close to the protrusion, and taxis tried, but in vain. He was then sent home, and within an hour I was at the bed-side accompanied by an assistant. After complete anæsthesia with chloroform, effort at reduction was still ineffectual, and we operated at once. The tumor was as large as a quart measure. The sack was adherent to surrounding parts. After reaching the hernial aperture we found that the constriction was within the abdomen at the neck of the sack, which felt like the neck of a bottle or jug. This being incised the reduction was readily made.

The hernial sack was dissected out with the purpose of securing it within the abdominal ring; when doubled up it was found to be rather voluminous. Half of it was then cut off, and the remainder being rolled up was placed in the hernial opening and securely fastened by numerous interrupted

stitches of catgut, extending from the plug to the inner wall of the canal. As an additional precaution the first stitch for closing the wound was passed deeply through the enclosed tissue, closing the rest of the wound with silk suture. A compress wet with biniodide of mercury was bandaged upon the part and left undisturbed four days. The antiseptic used on the sponges, and in the water for washing the incision during the operation, was a solution of hydronaphthol.

The surroundings were not good. The family had to live, eat and cook in one little room, with nothing but a cook stove and green wood to keep up warmth. During the time that we were operating, there was a blizzard blowing, and it was so cold in the house that in spite of towels wet with warm water, the bowel (a portion of the colon) was cold before we could reduce it.

Considering his unfavorable surroundings, persistent chronic diarrhœa, paralysis and albuminuria, we fully expected an unfavorable termination, but instead, his recovery was uninterrupted. The temperature never rose above 99°. In four weeks he was able to come to town, two miles distant from his home, with not the slightest evidence of a return of the hernia.

Society Reports.

AMERICAN MEDICAL ASSOCIATION. SECTION WORK.

Second Day, May 9, 1888.

SECTION ON DISEASES OF CHILDREN.

Dr. I. N. Love, of St. Louis, read a paper on

Membranous Croup and Diphtheria: are They Identical?

Since the appearance of Brettoneau's paper, about 1831, our first real and definite knowledge of diphtheria had its beginning, but the question of this paper has not yet been decided. After special clinical opportunities, Dr. Love took a pronounced position that membranous croup and dipththeria are identical. Dermatologists have given half a dozen different terms for erysipelas, yet, as a matter of fact, we know, pathologically speaking, that they are all one and the same disease, dependent upon the same germs and only varying in degree, action or manner of announcement. In fevers the same disposition was manifested, when typhoid fever, plus malaria as a complication, permitted the newly-coined term, typho-malarial. Whether the membrane, as in the so-called true croup, be a fibrinous exudation, superficial and easily stripped from the surface, leaving a smooth mucous surface only robbed of its epithelium, while that of diphtheria is more of a coagulation, penetrating or poured into the mucous tissues—a necrosis as it were, in which the eschar can be removed only with great difficulty—is not important, it being largely dependent upon the anatomical characteristics of the parts involved. That the disease is due to a special germ or microorganism is admitted, and the recognition of this pathological point in the treatment has made a much more favorable showing in the mortality reports. One fact which is worthy of notice, and which is an additional argument in favor of the identity of the two diseases, is that the classical treatment for croup has for years been free exhibition of the mild chloride of mercury, coupled with stimulation, with a view to its defibrinating effect. The secretory system has thus been stimulated, and the effect has been to favor the moistening and exfoliation of the exudation, and antagonize the disposition to constitutional involvement.

Since the same plan of treatment has been applied to general diphtheria, the tendency has been to the securing of a similar result, and the mortality reports present a more favorable showing. By the prompt recognition of the first appearance of diphtheria, and the immediate institution of imperative interference in the shape of free purging with the mild chloride, local antiseptics, rendering the infectious matter innocuous, and the continuance of constitutional measures which are germicides and stimulators of glandular action—first on the list being the bichloride, benzoate of soda, and large quantities of water—we can without doubt claim accomplishments that are tangible and positive.

Dr. Love closed his paper by saying he felt strong in the conviction that croup and diphtheria are one and the same disease, and that the teachings of pathological anatomy, as well as the clinical symptoms, would justify no other conclusion.

SECTION ON DERMATOLOGY AND SYPHILOGRAPHY.

The discussion on

The Limit of the Period during which Syphilis can be Communicated by Contagion or Inheritance

was opened by the reading of a letter from Dr. L. B. Bangs, of New York, in which he said that there was admitted to be a limitation to the contagious period of syphilis, and that this period was important in reference to the question of marriage. Dr. Bangs concludes from an analysis of eighty-seven cases

reported by M. Fournier, that we have absolute proof: First, of the non-contagiousness of syphilitic sequelæ, or so-called lesions of the tertiary stage of syphilis; Second, of the possibility of the spontaneous cure of the contagious stage of syphilis; Third, that the limit of the contagious stage in syphilis may be put within the period of five years. Dr. Jonathan Hutchinson does not think any case of actual contagion can be proven after two years. There is reason to believe, says Dr. Otis, that virus in the blood does not remain potent for contagion after the primary and secondary lesions. No instance is on record of contagion from a tertiary lesion or from one produced more than five years after the primary disease. The period might be shortened to three years.

Neumann thinks it probable that syphilis is caused by micro-organisms. After the disappearance of all the clinical symptoms of syphilis, he has found numerous exudation cells of a round and spindle-shaped form in the skin and mucous membrane. These cells, which were very infectious in the recent stage of syphilis, augmented and proliferated very rapidly. In the recent stage they could infect healthy persons if these were deprived of their epidermis. At a later stage the number of round cells is diminished, and replaced by spindle-shaped cells and connective tissue corpuscles. In the tertiary they grow more slowly. Still later they undergo fatty and caseous degeneration. These round cells are always present in the skin and mucous membrane during the latent stage of the disease, and form a continuous source of infection to the patient. Neumann also found the papillæ enlarged, the walls of the blood-vessels infiltrated with round and spindle cells, and the lymphatics abundant, as long as two or three years after the primary infection.

The question of *reinfection* might throw some light upon this question. That is to say, when a person has so far recovered as to become again infected, we may assume that at the time of the reinfection he was incapable of infecting another person. The author then cites eleven cases of reinfection, the average time elapsing after the primary disease being five years.

Dr. Palmer, of St. Louis, continued the discussion by saying that the question of reinfection had a close bearing upon the subject of marriage. Reinfection in other diseases, such as small-pox, measles, etc., forces us to acknowledge the possibility of reinfection in the case of syphilis. The question is, when can an uncured man marry? Is there a time when syphilis will not infect the wife? He believes we are still unable to differentiate between the times when a man is dangerous to his wife and when he is a syphilitic. In order to decide this question there are laws to be developed. When a man is well treated and obeys his doctor, he may marry in five years. We have this question before us in very many forms, but he does not believe that the current literature and knowledge of the matter are sufficient to establish any rule. The present tendency is to shorten the limit of the prohibition of marriage. If a syphilis germ be found, the spermatozoa cannot convey the disease. It would destroy it.

Dr. Keller spoke of a case he had had in 1877. The patient was sent to the Hot Springs soon after the appearance of the initial sore. Afterwards a constitutional treatment was employed. Despite his physician's protest, the man married in a few months. Some months later mucous patches appeared in the man's mouth. The wife was not infected. She was carefully watched through gestation and was perfectly well. The child was born with snuffles. In four or five days the skin became mottled, and in ten days the mother was spotted all over. The later children were well and the first child recovered.

Dr. Ravogli reported a case in which he knew the father and mother, and neither had syphilis. He had been called to attend the woman and had delivered her of several healthy children. But she later had a child which was sickly at birth. In two days syphilitic sores appeared. Three days later it died. The woman later had another child, (miscarried at eight months); when born the skin was badly macerated. Later, another child was born at nine months, but died. He thought in this case something was wrong with the mother. He referred to another case in which the wife had contracted syphilis from the husband, and where the treatment was unsatisfactory, because she could not be told what her disease was. A child was born and died. She has since had another child, which displayed syphilitic symptoms, which succumbed to mercury, and it is now doing well.

The next paper read was by Dr. Josef Zeisler, of Chicago, on

The Importance of Local Treatment in Syphilis.

There are few diseases for which our therapeutical actions are so well defined as for syphilis, yet when and how to use mercury and iodine is the great difficulty in treating

syphilis. The results of neglecting proper local treatment are often very serious. Although there is nothing especially new to be said upon the subject, yet as the text-books usually treat this question in a rather superficial manner, it may be well to call attention to the subject. Constitutional treatment is not, however, to be underestimated. The local treatment may be successfully employed in nearly every stage of syphilis, but those shown in the tertiary form are of the most importance.

Most physicians use the local treatment only for the primary indurated sore. I do not think that excision at this period can abort the disease, as the induration is a sign of constitutional infection. In the case of hard chancre I have found the mercurial plaster useful in making the induration disappear.

After the secondary symptoms have appeared, local treatment is useful. I prefer inunctions, which, besides their constitutional effect, have an undoubted local influence.

Patients generally desire the visible manifestations to disappear from the face and forehead, and for this purpose a ten to twenty per cent. ointment of the white precipitate is successful. For the papular syphilis on the palms and soles, the so-called psoriasis specifica, chrysarobin has been used from ten to twenty per cent. strength. Sigmund speaks highly of a one to two per cent. solution of sublimate in collodion, painted once or twice daily on the infiltrated places, avoiding the fissured places. Gilles de la Tourette recommended warm baths, with an addition of one part each of sublimate and of chlorate of ammonium to 2,000 parts of water. Papules on mucous membranes will yield to nitrate of silver.

More important are topical applications, for moist papules or condylomata, since these are especial sources of infection. For the removal of those vegetations different caustic pastes have been recommended, but they are very painful. I prefer cauterization with the silver stick, previously anæsthetizing the parts with a strong solution of cocaine.

There is rarely occasion to act against the swelling of lymphatic glands. For suppurating buboes surgical interference is necessary.

During any mercurial treatment the mouth requires attention, as the saliva soon becomes impregnated with the drug and causes mercurial stomatitis. Care of the teeth and gums, abstinence from tobacco and the use of an astringent mouth-wash will delay this. Sometimes it is necessary to suspend the administration of the mercury.

In later stages of the disease, local treatment is imperative, and is regarded by Hutchinson as more important than the constitutional. Iodides will not arrest the destruction caused by the ulcers on the skin and mucous membranes, and here local treatment is followed by the most brilliant results. What has been said of the value of local treatment of the skin applies still more to the eye, nose, throat, larynx, and other organs. When one of these is affected there is no time to wait for the effect of internal treatment.

Dr. Dumesnil, of St. Louis, called attention to the use of nitric acid. In anal and vulvar syphilides, he said, constitutional treatment was not efficient, but the local treatment frequently worked like magic.

Dr. Palmer said that the main thing to do was to look to the cause, rather than this or that particular agent. It was especially important to cut off the moisture on which the continuance of the growth depends. We should select our remedy with this purpose in view.

Dr. Ravogli said that he had good results from iodoform, where the patient can not bear other local treatment. As to the general treatment the great question was, how to introduce the mercury into the system.

The form used was indifferent, as it becomes sublimate. He preferred hypodermic injections, since they do not produce salivation.

Dr. Keller said that he made a special point to instruct the druggist not to furnish an ointment containing any form of petroleum. He found the animal fats far superior to mineral oils as bases of ointments.

Dr. Palmer expressed great satisfaction at what the last speaker had said. He had for the past ten years been studying the difference between mineral and animal fats and had found the animal fats superior.

Section on Practical Medicine, Materia Medica and Physiology.

Third Day, May 10.

Dr. I. N. Danforth, of Chicago, read a paper on

Evolution of the Cystic Kidney.

By cystic kidney is meant that condition of the organ in which it is more or less completely converted into a number of cavities, each uniting, containing fluid or semi-fluid matter, and possibly, solid matter as well. The number of these cavities varies greatly, sometimes being limited to half a dozen, or even less, sometimes reaching several hundred. The size of a cystic kidney varies greatly. Sometimes it is not perceptibly enlarged; at other times it is enlarged to three or four times its normal dimensions.

The cause of cystic or sacculated kidney may be classified as follows: 1. Diathetic causes: (a) excess of saline elements of the urine; (b) tuberculosis; (c) carcinoma. 2. Congenital causes: (a) floating kidney with consequent "twist" of ureter; (b) congenital hydronephrosis; (c) congenital degeneration of elements. 3. Mechanical obstruction consequent upon disease of the pelvic organs. 4. Traumatic causes. 5. Pathological cysts: dermoid cysts, hydatids, cystic metamorphosis.

Cystic Kidney Produced by Diathetic Causes.

By far the greater number of cystic or surgical kidneys occur during the active period of life, when the peculiar diatheses which lead to them are most likely to manifest themselves, and this is peculiarly true of the first group of cases—those produced by an excess of the saline element of the urine.

Tuberculous disease of the kidney does not often occur as a primary disease, although those who are much in the dead-houses of our hospitals find occasionally primary specimens, but whether the deposit be primary or secondary its behaviour is substantially the same. The tubercular deposit is most common in the cortex, and generally each deposit clusters around some arterial twig.

In the adult, carcinoma of the kidney is almost never primary, and it is a well-known clinical fact that secondary manifestations of renal cancer are by no means common. Moreover, when secondary cancer of the kidney *does* occur, it is not generally followed by cystic degeneration. Nevertheless, this does occasionally happen, and in the following manner: Cancerous deposits in the kidney sometimes occur as infiltrations, sometimes as round nodular deposits. In the latter case each nodule is surrounded and isolated by a fibrous capsule, composed of hypertrophied connective-tissue. By a certain process the cancerous nodule is gradually shut off from its blood supply, to an extent at least sufficient to induce early and rapid retrograde changes, fatty or mucoid degeneration; hence the solid cancerous nodule becomes transformed into a soft pultaceous mass, or even into a dirty yellow or grayish fluid. This generally finds its way into the pelvis of the kidney, and thence into the bladder. It sometimes happens that the first intimation of renal cancer comes from a profuse discharge of purulent or bloody matter by the urethra, which signalizes the fact that the cancerous nodule has undergone degeneration, and then tunneled its way to the renal pelvis, whence its escape is of course easy.

Primary cancer of the kidney is a disease peculiar to children "before the first or fifth year." It is almost always of the encephaloid type, and sometimes attains immense proportions. He has seen one case in which the cancer distended the abdomen to an almost incredible degree, while the alimentary canal, the liver, and other abdominal organs were compressed and crowded so as to be hardly recognized. In this case there were numerous cystic cavities, with fluid contents of a dirty-gray color, which were probably produced by the breaking down of isolated cancerous masses in the manner set forth.

Cystic kidney produced by congenital causes: migratory kidney with consequent twist or doubling of ureter. He used the term "migratory kidney" advisedly, to include both the movable and floating kidney, their anatomical and pathological relations now being well understood. The liability of the ureter to become twisted or doubled depends very much upon the range of movement which the organ possesses.

General Congenital Cystic Degeneration.

At rare intervals an infant is born, or is delivered instrumentally, with an enormously distended abdomen, due to the fact that the kidney has been converted into a "congeries of cysts" by a process of general cystic degeneration. Such a case is recorded in the *Medical Record* for January 21, 1888, and a few similar cases are on record. They are regarded as a peculiar form of cystic degeneration of the Malpighian bodies, but occasionally the convoluted tubules appear to be involved—in other words, only the functional or potential portion of the kidney seems liable to this form of degeneration, and even then the process probably begins during intra-uterine life.

Cystic disease of the kidney produced by mechanical obstruction consequent upon disease of the pelvic organs: diseases of the bladder; any form of cystic disease which produces thickening of its walls, or intramural infiltration so as to partially occlude the orifices of the ureter, is capable of inducing cystic kidney. The diseases of the bladder most likely to produce cystic kidney are inflammation, carcinoma, sarcoma, and tuberculosis.

He had recently seen a case of double hydronephrosis in a woman of about forty years of age, whereof the only discoverable cause was compression of the ureter by a much enlarged and prolapsed uterus. The

cervix uteri was enormously hypertrophied, tilted up against the bladder, and fixed in this position by adhesions, so that the ureters were constantly, though not very severely, compressed thereby. The consequence was partial retention of urine in the renal pelvis, and the slow but gradual and constant distention of the kidney until nothing of renal structure remained, except a thin layer of cortical structure just beneath the thickened capsule.

Malignant disease of the uterus not infrequently produces cystic distension of the kidney. Tumors of the broad ligament generally cause more or less complete stenosis of the corresponding ureter. Ovarian fibroids have been known to produce the same consequence, and pelvic cellulitis, especially when followed by extensive suppuration, is very likely to be followed by gradual closure of one or both ureters. In short, any pelvic disease which is followed by pathological new formations, or the dislocation of the pelvic organs, may produce compression of the ureters and cystic kidney.

The traumatic causes cannot be formally classified. Any injury of the kidney may result in cystic disease, but *how* and *why* we cannot always explain. As an example, he had seen a short time ago the case of a young man who fell down a rough and precipitous hillside, thereby receiving some injury of the right kidney, which was followed by pain, tenderness and hematuria. These symptoms shortly subsided and the patient regarded himself as quite well, yet the kidney remained slightly tender. He had occasional, but not severe, attacks of nephralgia, and four years after the injury he died after nephrotomy, the kidney being an enormous multiple abscess.

FRENCH ASSOCIATION FOR THE ADVANCEMENT OF SCIENCE.

SEVENTEENTH SESSION, AT ORAN, ALGERIA.[1]

(Reported by Arthur C. Hugenschmidt, M.D., Paris.)

Fourth Day, April 2, 1888.

President, Dr. Cros (Oran.)

Multiple Thrombosis.

Dr. Fabriés (Sidi Bel Abbes) treated in November, 1887, a young man 19 years old, suffering with pneumonia, which lasted ten days. On the twelfth day he developed thrombosis of the right crural vein, and a week later the left crural vein was involved. By December 20, all symptoms had disappeared, there only remaining an indurated cord along the course of the vein. On January 10, after a walk, he was taken ill with gastric disturbance, followed by hæmaturia and pain in the region of the right ureter; this disappeared on the fifth day. On the eighth day the trouble recurred on the left side. The urine showed a few fibrinous casts. On January 25 he vomited a large quantity of blood, and had three bloody stools. On February 10 pain in left side and bloody sputa, indicating obliteration of the left pulmonary vein, occurred. All these accidents were without doubt due to a thrombosis of the veins which supplied the different organs involved: obliteration of the renal veins produced a congestion of the kidney, terminating in hæmaturia and albuminuria, which is exactly what occurs when the circulation in the renal vein is arrested experimentally.

Treatment of Idiopathic Hydrocele by Electrolysis.

Dr. Spreafico (Oran) found that the use of electrolysis in the treatment of idiopathic hydrocele was very efficacious. Moreover, the treatment causes very little pain and takes a very short time. No bad effects are to be feared from its employment. He has even employed this treatment in hydrops articuli. Dr. Cros admits that albumin will coagulate on account of the current, but he would like to know how the liquid is absorbed, as he thinks that absorption must be rendered more difficult if the tunica vaginalis is lined with a layer of albumin.

Primary Infectious Orchitis.

Dr. Hublé (Marnaia) has observed for the past five years a series of ten cases of orchitis, which have appeared spontaneously, without any relation to the usual causes, namely, syphilis, gonorrhea and tuberculosis. He ascribes to it the following clinical characters: It usually appears first by a fever of the remittent type; the epididymis is involved at the time when the fever appears, or may be later; the gland itself is sometimes affected, but remains smooth and nearly painless; sometimes slight effusion occurs into the tunica vaginalis. This orchitis is usually accompanied by slight involvement of the joints, with jaundice, purpuric or other eruptions, and sometimes a temporary albuminuria. The average duration is from four to twelve days. Recurrences are observed. The prognosis is not serious; atrophy of the testicle is sometimes observed as a sequel. The

[1] Continued from page 572.

treatment employed is compression of the part with cotton-wool, and quinine and purgatives internally. The causes of this orchitis are probably to be found in the climate, and there are also the individual, general or local causes. He thinks the malarial micro-organisms might have a part in the production of this trouble.

Medical Treatment of Tubercular Patients.

Dr. Verneuil (Paris) always employs medical treatment before he resorts to surgical intervention in tuberculous patients. He puts all his patients previous to operating on a preparatory treatment consisting of one grain of iodoform every day for four weeks, and when the patient has been operated upon, he continues what he calls his post-operative treatment, divided into two parts: the one, which is internal and pharmaceutical, is still iodoform—he resumes it eight days after the operation; the other, the most important one, is emigration. He then proceeded to say:

By emigration, I mean the removal of the patient from the place in which he contracted the disease and in which he has been operated upon; of these places there are two sorts: curative places (mineral springs, etc.), and places where the air is perfectly pure. The two following cases will illustrate.

A young man, 30 years old, had been operated upon before for a coxalgia, with perfect success. He remained with an ankylosis and sub-luxation of the hip-joint. When 27 years old he had irregular pains in that same hip-joint, and soon an abscess formed around the articulation. As I did not like to open the part and scrape it, I sent the young man back to his country home, where the pus was aspirated. He was kept in bed for fifteen days, and the abscess did not reform. He was then compelled for one reason or another, to emigrate to Algeria, and since then he has been in perfect health. My second patient had numerous anal fistulæ, which had troubled him for fourteen years. I operated on this man, and he left the hospital much better, but not quite cured. He also came to Algeria, by chance, and is to-day perfectly cured and in a perfect state of general health.

Gymnastic Treatment of the Period of Asphyxia in Cholera.

Dr. Pauly (Oran) observed during an epidemic of cholera in 1859, that French soldiers, when their comrades were taken with cholera, forced them to walk about, by sustaining them if they were too feeble to walk themselves, and that good results had followed this practice. He applied this treatment in his ambulance during the last epidemic with gratifying results. It cannot be ordered for patients already invalids, who are attacked with cholera, or for very old people; but all other patients ought to be submitted to it. This method is excellent in day time, still more so at night on account of the cool atmosphere, and still better if there is a light rain, for these will stimulate the peripheral circulation which seems to be at fault, and so combat the asphyxic stage. As adjunct to this treatment, friction can be applied to the hands and face of the patient, with a napkin dipped in very cold water, while he is walking about. This walking can take place anywhere in a garden, on a terrace, on a public place, or even in a large room, the windows being wide open.

On the Prognostic Value of Ampullar Dilatations of the Tongue.

Dr. Gillot (Autun) has remarked on the internal surface of the tongue, in the line of small vessels and capillaries, more of less numerous and well developed dilatations, presenting the same structures as miliary cerebral aneurisms. He has found a close relation between these aneurismal dilatations of the tongue and analogous alterations of the cerebral capillaries. These vascular lesions he has found always related to the arthritic diathesis. Their existence lead one to suspect the presence of the same in the cerebral vessels, and can help to make a prognosis in cerebral affections.

Note on a Case of Polydactylism and Syndactylism.

Drs. Seguy and Levy (Algeria) present the mould of a young Jewish girl's hand, bearing seven fingers, including one supplementary ring finger and a little finger, the two ring fingers being united by an interdigital membrane. The skeleton was complete even to the nails; they were both articulated with the corresponding metacarpus. The restoration consisted in the disarticulation of the two fingers. A dry dressing with sawdust and bichloride of mercury was applied.

Convulsive Tic Cured by Hypnotism.

Dr. Burot (Rochefort) has employed this method on a young woman 20 years of age, who for fifteen months had convulsive tremblings of the face, accompanied by the involuntary use of more or less obscene words. The young woman is now cured after one year's moral treatment. This disease, he says, is due to a want of equilibrium between the sphere of intellectual activity and the sphere of cerebral automatism.

Moral gymnastics replace the equilibrium to the advantage of the intellectual sphere.

Rare Form of Spermatic Cyst of the Scrotum.

Dr. Vautrin. The spermatic cysts are said to be scrotal tumors, containing a milky fluid and spermatozoa. I have two cysts from one individual, and find the wall to be composed of a ciliary cylindrical epithelium—a layer of unstriped muscular fibres and a layer of connective tissue. This is the histological constitution of the vas deferens and vasa aberrantia. I concluded that these vasa aberrantia may lose all communication with the vas deferens, and so constitute isolated cysts, containing spermatozoa. Spermatic cysts are formed in the remains of the Wolffian body. For cysts outside the tunica vaginalis the operation is an easy one, but for cysts within the tunica vaginalis the latter must be incised beforehand, which operation he thinks preferable to the injection into it of an irritant liquid. With antiseptic measures we need have no fears of the consequences of the operation.

Dr. Verneuil does not employ incision for the treatment of cysts within the tunica vaginalis, but prefers the injection of iodine, which, he says, nearly always succeeds in these cases.

Fifth Day, April 3.

President, Dr. Cros.

Dr. Trolard (Algeria) read a paper on the Prophylaxis of Hydrophobia, and also one on Naval Quarantine.

Treatment of Mental and Nervous Diseases by Hypnotic Suggestion.

Dr. A. Voisin (Paris) has continued his observations, and has treated a case of melancholia, with hallucinations and suicidal tendency. The disease had lasted two months, and was cured in fifteen days. He has also treated a case of melancholia with agitation and violent impulses. This was cured in two consultations. A hypochondriac, suffering with chronic nervous troubles, which had lasted eight years, and with a beginning paraplegia, was cured in three sittings. A case of dipsomania of ten years standing, associated with melancholia, was cured in the same manner. In insanity with excitement he produced hypnotic sleep. During the catamenial periods he suggests to the patients to sleep from the beginning of their menstrual flow for six or seven days, allowing them to get up only when it is necessary. These cases were cured. Their insanity might have been hysterical or not; the important point, he says, is that they are cured.

Dr. Grasset recommends successive hypnotization, from which most surprising results will be obtained. At the beginning the suggestive power must be concentrated exclusively on sleep. He has himself cured an hysterical paralysis, which had lasted six months.

Extirpation of Deep and Benign Growths from the Soft Parts of the Palm of the Hand.

Dr. Gross (Nancy) presents two cases of this kind.

Case I.—A young man, 25 years old, had a spongy osteoma in the middle of the palm of the hand, behind the flexor tendons of the fingers and in front of the superior extremity of the fourth metacarpal bone. The growth had no connection with the bony skeleton of the hand; it was either an epiphyseal exostosis or a parosteic osteoma of Virchow. Excision was performed by passing between the tendons of the fourth and fifth fingers.

Case II.—Fibroma of the upper portion of the hollow of the hand, in front of the tendons and ulnar artery and nerve. The method of choice for extirpation of the deep tumors of the hand, is the one which consists in reaching the sub-tendinous region by passing between the tendons of the fourth and fifth fingers and the terminal trunks of the median and ulnar nerves.

Amputation of the Leg.

Dr. Duzea (Lyons) read a paper on the preservation of the periosteum of the calcaneum in amputation of the inferior extremity of the leg. Long ago Prof. Ollier, of Lyons, had proposed to save the whole periosteum of the calcaneum in amputation of the lower extremity of the leg, with a large posterior plantar flap. Dr. Duzea thinks that in all such amputations of the leg, a very important matter is to remove completely the calcaneum, but to reserve with the greatest care all the periosteum of the same. The operation is a simple one. The counter opening must be made, of course, as low as possible; the tendo Achillis must be cut and the suture of the extensor tendons of the plantar aponeurosis must be performed; a posterior splint in plaster-of-Paster, curved below and in front, will complete the treatment. This method will protect against hemorrhages, as the principal artery of the flap is not cut, and the nerves and vessels not being injured, will prevent the occurrence of any trophic changes or mortification; in all cases the calcaneal periosteum, which has been preserved, will form a new bone, which will render the stump much stronger.

Dr. Marchand (Paris) thinks this operation an excellent one in traumatic amputations, but he prefers a much more extensive amputation in cases of tubercular lesions.

Dr. Duzea thinks that it is objectionable to keep even diseased periosteum; for Prof. Ollier has long since proved this. He does not, in these cases, look for a primary union; but leaves a drainage-tube in the wound and occasionally injects iodine solution to irritate the surface, and has had no recurrence of the disease.

MISSOURI STATE MEDICAL ASSOCIATION.

THIRTY-FIRST ANNUAL SESSION, HELD AT KANSAS CITY.

April 17, 18 and 19, 1888.

The meeting was called to order promptly by Dr. F. J. Lutz, of St. Louis. The Association was welcomed in an address by Mayor Kumpf, of Kansas City.

Investigations throughout the State concerning Phthisis Pulmonalis

was the subject of the remarks by Dr. B. F. Host, of Brownsville. He found that pulmonary consumption was not on the increase. He found it not so prevalent here as in the older countries of Europe where population was denser. He thought it contagious, but not in the same manner as disease is usually considered contagious. He deplored the wonderful ignorance of the danger of the disease among the old and the young, and hoped that knowledge would be disseminated among the people concerning this disease. He thought many errors were made on the part of physicians, especially in sending patients to other climates, and that at least six months should be taken in passing from a low to a high altitude.

Practical Points in Railroad Surgery

was the subject of a paper by Dr. Willis P. King, of Sedalia, who explained the pain which occurs in lacerated wounds by the necrosis of the soft parts, the contact of the dead and dying with the living tissues. In proof of this he cited the fact of the disappearance of the pain when the diseased tissue was removed. He preferred a secondary operation in amputations of the lower extremities. In railroad injuries where there is much crushing he was inclined to favor the cutting away the crushed parts, dressing the limb antiseptically and waiting for the absorption of effused blood and the return of the normal condition of affairs before doing an amputation. In amputating between the ankle and the knee-joint he makes a flap amputation which is of his own design, and which will be known as the King's flap. He makes the entire flap from the posterior part of the leg, and removes the soft parts anteriorly from one to two inches above the point at which the bone is divided. This is especially suitable at a secondary operation, when the injury has been mainly on the anterior part of the leg. The object of the flap is to throw the line of the cicatrix above and to the side. In operations about the feet, when it is necessary to go further back than the tarso-metatarsal joint, he favors sub-astragaloid disarticulation. He employed scissors in place of the knife in exsecting in this operation. They facilitate the operation very much, and make a much nicer result. He uses straight scissors on the sides and bottom and curved scissors behind. He laid great stress on the use of scissors. In all operations he urged the strictest application of antiseptics. He thought them of possibly even greater benefit in crushed injuries than in others, for the reason that crushed wounds are ten times as apt to have septic infection as others. Immediately after the time of injury a person is in the most imminent danger of septic infection.

The State Board of Health

was the subject of a paper by Dr. George Homans, of St. Louis, who is Secretary of the Board. It is much crippled for want of means, but is doing some good in restricting practice to those legally qualified.

Gynecology, Testicology, and Comparative Sterility in the Male and the Female

was the subject of a paper embodying the report of several interesting cases by Dr. Edward Borck, of St. Louis. The progress in the treatment of gynecological affections he thought had been wonderful and the cures so remarkable, that the present generation will be entirely free from suffering before long. From the latest returns it is safe to say that nine women out of every ten have some tilting up or sinking down of their organs, or the opening of the uterus is too large or too small. Why have women, or rather their sexual apparatus received so much attention from medical and other men? Is it because we all love women so much that we are wholly absorbed in the welfare of their reproductive organs? The diseases of the testicle receive little attention. New works are not springing up on

every side. Are the ovaries in women not generally considered the analogue of the testes in men? The profession has given to the former organs the kindest attention possible; to the latter almost none. If only one man in ten is affected with a disease of the testes, what a rich field for study and inquiry for the testicologist. Women suffer from neuralgic pain in the ovaries, and men suffer from neuralgic pain in the testes. When all known remedies fail, woman cheerfully gives up her ovaries; but it is not so with man. He suffers and suffers, and in some cases lands in the insane asylum, and takes his testes with him. Yet the removal of the testes is not nearly so dangerous an operation as the removal of the ovaries. The author was a strong advocate of specialties in medicine, and believed in specialists; but he did not believe that every new graduate should rush off to Europe at once to study a specialty and after three months return a full-grown specialist. Such a man has one-sided ideas unless he does his share of general practice first.

The author then reported a number of cases illustrating his remarks; one of which was that of a healthy young woman whose husband was apparently well, and yet who after four years had no children. The family physician exhausted himself, then turned the case over to a gynecologist, who discovered at once the least bit of tilting of the womb. Every time the woman visited him, he told her she was growing better. But the woman did not agree with him, and at last in a state bordering on insanity she was turned over to a neurologist, who said her nervous system was out of order—and by this time it certainly was. The neurologist failed, however, to cure her, and she came into the hands of the speaker. He found the diagnosis of his predecessors correct, but he could not consider either the woman's womb or her nerves the cause of her sterility. He therefore sent for her husband, and found that he suffered from fatty degeneration of the heart, and had fatty deposits in the scrotum and testicles, and fatty degeneration of the spermatozoa. Temporary separation from his wife was advised, and after six months' absence in Europe he returned and in due time a boy baby was born. In another pair, of which the wife was treated for sterility and the husband for brain trouble, examination showed a left testicle hypertrophied from epididymitis. After removal of the offending organ, his wife in due time gave birth to a child. Two other such cases were reported.

Sympathetic Affections of the Eye Viewed from a Modern Standpoint

was the subject discussed by Dr. Adolph Alt, of St. Louis. He was of the opinion that sympathetic affections of the eye should be as well known to the general as to the special practitioner. Eyes which have suffered a perforating injury are most apt to cause sympathetic trouble. Of this affection there are two kinds: irritation and inflammation. All sympathetic troubles unless treated soon enough lead to total blindness. A direct inflammation of one eye can take place from the other through the optic nerve. To prevent the disease he recommended the removal of the injured eye.

The First Care of the Injured

was discussed by Dr. A. H. Meisenbach, of St. Louis. He thought that railroad men should receive instruction in rendering first aid to the injured. There was thousands of cases in which a little knowledge would be of inestimable value.

Leprosy, with a Report of a Case

was the subject of a paper by A. H. Ohmann-Dumesnil, of St. Louis. This case was said to be the first one ever observed in St. Louis.

The Election of Officers

resulted as follows: *President*, A. W. McAllister, of Columbia; *Vice-Presidents*, J. D. Griffith, of Kansas City, J. H. Britts, of Clinton, W. A. Camp, of Springfield, H. C. Dalton, of St. Louis, and J. B. Winn, of Macon; *Secretaries*, J. C. Mulhall, of St. Louis, and J. H. Duncan, of Kansas City; *Recording Secretary*, L. I. Mathews, of Kansas City; *Treasurer*, C. A. Thompson, of Jefferson City. Springfield was chosen as the next place of meeting. At the present meeting there were 269 members enrolled—the highest number ever reached.

—At a meeting of citizens, in Association Hall, Philadelphia, May 9, under the auspices of the City Parks Association, the necessity of more small parks for breathing spaces was advocated, and a memorial urging the passage by Councils of the ordinance to establish at once seven of the twenty-one parks proposed was approved. Several well known physicians spoke of the importance of such parks to the healthfulness of the city, and Professor Rothrock urged the necessity for a botanic garden. A letter was read from Dr. Isaac Norris containing a resolution passed by the College of Physicians of Philadelphia, warmly approving the objects of the Association.

Foreign Correspondence.

LETTER FROM BERLIN.

Berlin, April 6, 1888.

In the Dermatological Society of Berlin, Dr. Isaac, Dr. Lassar's assistant, has recently showed a rare case of lichen-ruber occurring in a child only fifteen months old. This disease, described by Hebra, usually appears between the age of ten and forty years. Dr. Isaac says that only two cases of such young children have been reported in medical literature. Dr. Lassar believes lichen-ruber to be infectious and that it is frequently to be found in people occupied in the preparation of articles of leather. The case mentioned above confirms this opinion of Dr. Lassar, as the child often played with a shoemaker.

In one of the last meetings of the Medical Society of Berlin, Dr. Behrend described a new remedy for skin diseases, called anthrarobin. Professor Liebermann, of this city, discovered this chemical compound. Dr. Behrend thinks this new remedy can be applied for all skin diseases which have been heretofore treated with chrysarobin; for instance, psoriasis and tinea tonsuraus. Psoriasis is healed by the application of chrysarobin more promptly than by that of anthrarobin. The latter is, however, sometimes to be preferred on account of its not being so irritating. This is especially true in cases of psoriasis of the eye-lids, or near to the same, since it is possible to cause inflammation of the eye by using the former. Dr. Behrend highly recommends anthrarobin in cases of tinea tonsurans. All the cases of this disease which he has treated with anthrarobin have recovered, and he has never seen any marked inflammation of the skin arising from the application of this remedy. In regard to the method of using anthrarobin, Dr. Behrend recommends applying the tincture and not an ointment.

In referring to some passages which are to be found in a very interesting medical pamphlet of Dr. Leopold Casper (Beiträge zur Pathologie and Therapie der Harnröhrenstricturen, *Berliner klinische Wochenschrift*, 1888, No. 11) I call your attention to the following: With regard to liability to the formation of the stricture of the urethra, it is just the same whether the gonorrhœa has been infectious or not. Simple traumatic gonorrhœa may lead to a stricture if the inflammation attacks the deeper layers of the mucous membrane. With reference to the diagnosis, Dr. Casper recommends the use of Leiter's endoscope in some difficult cases in which the seat of the disease is in front of the bulbous portion of the urethra. As to the treatment of the stricture, Dr. Casper is of the opinion that dilatation is sufficient in ninety per cent. of such cases, and that a bloody operation is seldom necessary.

During the month of March two new *cheap* bathing-places for the working-class, have been opened in Berlin. They have been established by a society whose main object is to offer cheap baths to the poor people of Berlin. Our working class here is as a rule, extremely cleanly, both in regard to their clothing and their person. However, the number of warm baths is, taking all in all, too few in comparison with the population, and likewise the prices of the same are too high to allow the working men to make use of them. The fact has been announced by Dr. Oscar Lassar, of Berlin, that instead of there being a warm bathing-place for each thousand inhabitants in Germany, there is only one for each thirty thousand. Through the untiring interest and the energetic efforts of Dr. Lassar an inquiry with regard to the matter has been made throughout Germany. At the Hygienic Exhibition of 1883, the attention of the friends of the poor was drawn to a small bathing establishment in which shower-baths with soap and a towel were given for two and one-half cents. It was likewise the work of Dr. Lassar. In a closed compartment the whole body can be soaped over, and then the soap rinsed off by means of the shower-bath, which first of all pours down warm water, and then becomes gradually colder. Everywhere, bathing establishments according to the system of Dr. Lassar could be erected and kept in working order, for instance in manufactories, schools, barracks, asylums, etc. For the present, here in Berlin shower-baths are combined with sitz baths. These baths are being greatly frequented by the working-class, proving how great the demand for them is. It is a matter for congratulation that a physician has not only noticed the necessity for such baths, but has likewise been able to propose the proper method of putting them into successful operation. Everywhere in Germany, and also abroad, thanks to the kind efforts of Dr. Lassar, the working-class will, before long, have the opportunity of getting cheap warm baths. In this thing alone the science of hygiene has made a rapid onward stride.

Albert Moll, M.D.

Periscope.

Selection of a Climate for Patients with Pulmonary Tuberculosis.

Dr. Frederick I. Knight, in a paper read before the Boston Society for Medical observation, March 5, 1888, gave the result of his twenty years' experience in the selection of a climate for patients with pulmonary tuberculosis. After some remarks upon the main facts which should guide the physician in recommending a change of climate, Dr. Knight gave the following as the principal types of the disease, with the indications of each as to change of climate.

(1) Those presenting the earliest physical signs of tuberculosis of the apex; who have as yet shown little, if any, general disturbance from the disease, and who complain only of morning cough and expectoration. Threatened cases of hereditary disease, in which there are as yet no morbid physical signs, and not much constitutional disturbance, may usually be considered with this class.

It is, perhaps, not saying too much to say that the prognosis has been changed as regards this class of cases from very bad to very good. While he has had such patients do well in different climates, some of them without leaving home, the results have averaged far better, in his experience, in those who have sought mountain climate than in those who have pursued any other course. The region which he has found best for this kind of treatment is the eastern slope of the Rocky Mountains, in the States of Colorado and New Mexico, where the altitude ranges from 4,000 feet to 8,000 feet.

The question, he says, will naturally be asked whether the patient should go at once from the sea-board to such a high elevation, or make a number of stops on his way out, in order to become accustomed to the diminished pressure. He has never known any ill effect in patients of this class from making the change at once; but it is especially necessary that they should consult a good local medical adviser at once, that they may be guided from the beginning, especially in regard to the kind and amount of physical exercise which they should take.

(2) Patients with more advanced disease, showing some consolidation, but no excavation, nor any serious constitutional disturbance. The mountain climate, he says, is suited to many of this class also, and it is fortunate if they are in condition to try it, but if a considerable area of one lung, or the apices of both, are consolidated, and there is well-marked constitutional disturbance, if the pulse and temperature are both constantly above 100, then it may be well to try some low altitude first. For very low elevations, the dry, rather stimulating air of Aiken and its vicinity, or the pine regions of Southern Georgia, may be recommended for the greater part of the year, the patient going north in the summer. When quiescence in the morbid processes is established a move to the higher altitudes should be made.

(3) Hemorrhagic cases, that is, patients in whom pulmonary hemorrhage has been perhaps the earliest, and a frequently recurring symptom, but in whom there is as yet no marked febrile reaction, nor much physical evidence of disease.

This class, he says, seems especially suited to the high altitude treatment. Contrary to the old idea, these patients appear to be less liable to hæmoptysis in high altitudes than on the plains. He usually advises such patients to make several stops on their journey upward, but does not think this precaution often necessary. What he says in this connection is not meant to refer in any way to the hæmoptysis from rupture of a large vessel in a cavity of advanced disease.

(4) Cases of advanced disease, those with cavities or severe hectic symptoms. Patients of this class, he says, had better, as a rule, stay at home; certainly, if they are sick enough to be confined to the house. They can usually be made much more comfortable in their own homes than at any health resort; yet he has sometimes advised that such a patient with very constant and harassing cough be sent to the moist climate of Florida, and the relief to the cough has more than compensated for the want of some home comforts. A poor patient, or one without abundant means even, should not, he says, be given such advice.

(5) Patients in an acute condition. These may be quite different in their nature and requirements. We find, he says, (*a*) cases of acute general infiltration. These patients should be kept at home definitely. (*b*) Cases which begin violently with high fever and marked consolidation of lung, resembling pneumonia. Patients of this class should be kept at home till after the subsidence of the acute symptoms, and then may be removed to some low, dry place; afterward increasing elevations may be carefully tried. (*c*) Cases of acute exacerbation during the progress of chronic disease. Patients of this class should remain at home during the acute stage, going perhaps, to some mild, sedative climate dur-

ing its decline; but as soon as possible after the febrile disturbance is well over, if their condition otherwise warrants it, they should go to an elevated region.

(6) Cases of so-called fibroid or interstitial pneumonia.

Special indications in these cases have to be considered. If the patient is young, and the heart is not enlarged, he may be sent to high elevations. If he is over fifty years of age, or if his heart is dilated, or if his cough is very harassing, a lower altitude should be chosen. Southern California offers excellent places for such, with varying elevation and moisture to suit individual symptoms.

(7) Patients recovering from acute pleurisy or pneumonia, in whom the eruption of tubercle is feared. High elevations is the place *par excellence* for these. The increased respiratory, and consequent increased nutritive activity are exactly what is wanted to prevent the development of chronic disease.

(8) Patients in whom the tubercular process has seriously invaded the larynx.

Such patients he says, should be recommended mild, and even moist climates, and on no account be sent to high altitudes. Southern California he thinks answers the purpose well. The dry air of high altitudes, however, much good it may do by stimulating general nutrition, usually proves so great a local irritant to the larynx that incessant cough ensues, or, if the disease is situated high in the larynx, the swelling and ulceration of the cartilages are aggravated so that severe dysphagia and insufficient nourishment ensues.

(9) Those with complications of other diseases.

In regard to these, he says, a good deal of care has to be exercised oftentimes. In cases of cardiac affection it may be said, that while marked dilatation should prevent a patient's being sent into a high altitude, it is not necessary to exclude every one from such who has a cardiac murmur, or who even is known to have organic valvular disease, with moderate hypertrophy; but such patients should be carefully watched and regulated in their habits, and should not be sent into the very highest altitudes.

In regard to renal disease, while it is admitted by the resident physicians that *acute* nephritis is severe in high altitudes, they do not admit that patients with chronic disease are made worse, but claim rather that they are benefited by a residence there.

Patients with intestinal ulceration are said to do badly in high altitudes, but they do badly everywhere.

In regard to the rheumatic diathesis, it may be said that acute rheumatism is thought to be rather prevalent and severe in high altitudes, and such a tendency might turn the balance in favor of a lower resort. On the other hand, the chronic form of rheumatism does not seem to be made worse by elevation. —*Boston Med. and Surg. Journal*, April 5, 1888.

Cerebral Symptoms in the Pneumonia of Children.

Dr. L. Emmett Holt, Attending Physician to the New York Infant Asylum, in a paper read before the New York County Medical Society, March 26, 1888, discussed the Cerebral Symptoms in the Pneumonia of Children. His paper was based upon an analysis of 173 cases, which were divided as follows:

Seventy-three were lobar pneumonia, with two deaths; and one hundred, broncho-pneumonia, with a mortality of thirty-four. The sexes in broncho-pneumonia were nearly equal; while in lobar pneumonia the males predominated, forty-three to thirty. As to age, one hundred and twenty-three patients, he says, were two years of age or under, and only thirteen were over five years of age. Thirty-four cases, or twenty per cent. of the whole number, presented decided cerebral symptoms. These were divided into three groups: Those attended by convulsions, of which there were fourteen; those in which delirium was the principal symptom, twelve in number; and the third class, in which neither convulsions nor delirium existed, but other symptoms decidedly cerebral in type—of these there were eight cases.

He concludes his paper with the following deductions:

"1. Cerebral symptoms in the pneumonia of children are very common.

"2. Convulsions belong almost without exception to infancy, being rarely met with after two years. Occurring at the onset, they belong essentially to lobar pneumonia; they do not indicate a bad prognosis, nor even, in most cases, a severe attack. When late convulsions come on, death within twenty-four hours may confidently be predicted.

"3. Delirium comes oftenest between the ages of five and eight, usually in conjunction with extensive disease and high temperature. These cases, although severe, with but few exceptions, recover.

"4. There is no such intimate association between certain symptoms and apex disease as has been frequently stated. Such symptoms occur in only about one fifth of the apex cases.

"5. Nervous symptoms occur much more frequently (one-third of the cases), when the disease is extensive and the temperature very high.

"It was not my purpose to enter into the subject of the treatment of these symptoms in pneumonia, as I have nothing new to contribute. I wish to emphasize two points which my experience has taught me. The first is that in hyperpyrexia the cold pack is safe, and the most efficient means to reduce the temperature and thus abate the brain-symptoms dependent upon it. The second is the use of antipyrine, not so much for reducing very high temperature—for I think the cold packs are safer than very large doses, and altogether more satisfactory—but to allay restlessness, quiet delirium and cough, and promote sleep. For this purpose, doses of two or three grains are sufficient in an infant of from six to nine months, and double the dose at eighteen months or two years. The dose may be repeated every six or eight hours."—*Medical Record*, April 7, 1888.

Treatment of Chronic Pyelitis.

In the *American Journal Medical Sciences*, March and April, 1888, Dr. Nathan Bozeman, of New York, publishes an article on chronic pyelitis successfully treated by kolpo-uretero-cystotomy, irrigation of the pelvis of the kidney, and intra-vaginal drainage. He has used the method successfully in two cases. In the first, drainage was provided for by a large urinary fistula; in the second, kolpo-uretero-cystotomy was done to provide drainage and allow of catheterization of the ureters. The evils of incontinence of urine were prevented by using the author's intra-vaginal drainage apparatus. The renal pelvis was irrigated through a French catheter, passed up the ureter. Bozeman has also devised a flexible metallic sound for exploring the ureter; by this calculi can be more easily felt. When treatment was begun in the second case, the renal pelvis held twenty-one drachms, but the capacity diminished to five drachms while under treatment. This is considered the normal capacity. Acute pyelitis was several times induced by the passage of too large an instrument, by allowing the catheter to remain in situ longer than twenty-four hours, and by deficient antisepsis. The fistula was closed after about seven months, by the author's button-interrupted suture. By using the author's intra-vaginal drainage apparatus during much of the time the patient was under treatment she was enabled to perform her daily duties and enjoy the pleasures of life.

Bozeman considers that an artificial fistula at one of the ureteral angles of the trigone of the bladder, furnishes an opportunity for the observation and clinical study of diseases of the bladder, ureters, pelvis and kidneys afforded by no other means. He has not been able to catheterize the ureters free-hand; and condemns catheterization through the dilated urethra, since dilatation sometimes results in permanent incontinence of urine. Not only is catheterization facilitated by the formation of a fistula, but by no other method is vesical drainage afforded; nor would it be practicable to irrigate the renal pelvis daily for a protracted period, except through a fistula. Physiological rest and perfect drainage of the bladder, ureters and pelvis, afforded by this method of treatment, tend to cause the subsidence of inflammation of their lining membrane and atrophy of their thickened muscular coats. In consequence of the removal of the pressure of the urine, an enlarged bladder or a dilated pelvis returns to its normal size.

This method of exploration and treatment is likewise useful, not only in ascertaining the indications for nephrotomy and nephrectomy, but, when employed early, by curing the conditions, which, when neglected, lead to extensive renal disease, in lessening the number of cases in which these grave operations are necessary. Congenital absence of one kidney, coincident disease of both, and pyelitis on both sides, are contra-indications to the performance of the operation of nephrectomy, but not to the employment of this method of treatment.

The use of intra-vaginal drainage in preventing the evil consequences of incontinence of urine, perfects the method by removing the chief objection to its employment.

Nervous Symptoms arising from Displacements of the Uterus and its Appendages.

Dr. Grace Peckham, in a communication on this subject to the *Medical Record*, Feb. 18, 1888, concludes as follows:

From an inspection of these cases, as well as looking through the very many others which were not sufficiently typical to come under classification, the following deductions have been made:

1. Nervous disturbance outside of the pelvis is not nearly as frequent in disease of the uterus and its appendages as is generally believed. The impression that one severe case makes effaces that of dozens of simpler ones.

Moreover, gynecologists who are men, are apt to meet only the severer cases, since women suffer long and in silence before undertaking a treatment which does such violence to their natural modesty. The eminent specialists who have done most of the writing on this subject encounter the most severe and difficult cases, and their object, often, in writing, is to present peculiar and extraordinary cases.

2. It has been shown that mere mechanical displacements give rise to almost no disturbance in complete prolapsus. In the other degrees of prolapsus the pain comes from the pulling and stretching of the tissues. Retroflexion occasions the most nervous disturbance outside of the pelvis.

3. It can be seen that the amount of disturbance is in every way proportioned to the amount of uterine tissue involved, and the length of time the disease has continued.

4. It is plainly shown that the reflex nervous symptoms are no more severe nor extensive that arise from diplacements and inflammatory conditions of the uterus and its appendages than would be produced by pathological conditions of the same extent and the same chronic character in other parts of the body. When these are present a previous neuropathic tendency, either acquired or inherited, probably has existed, and the uterine trouble is generally extensive and of an aggravated nature, which, acting on the central nervous system, produces a display of disturbed innervation at the periphery, or of disturbed cerebration, which results in neuralgias or hysterias.

5. In these studies the effects of uterine trouble upon the eyes have been carefully considered. Three cases, two of endometritis and one of inflammation of the broad ligaments, are found. I have met others, but in these, and looking over the literature, I have reached the conclusion that the eye-trouble is generally due to anæmia and general asthenia, and it is doubtful if it can be proven that such troubles with the eyes occur more often in uterine diseases than in others which would produce a similar state of anæmia and depression of the general bodily strength.

6. Many nervous symptoms are not present *because* of uterine disease, but are due to the constipation and anæmia with which it is so often accompanied.

7. Nervous disturbances outside of the pelvis are much more prevalent among the more highly organized women of the higher classes than among those of the lower, who have less time to think of themselves, and much less vivid imaginations.

8. The attention should be called to the fact that sacral neuralgia often simulates uterine disease; the pain is very much like that described in many of the inflammatory conditions with displacement, and even with ovarian trouble. It is often associated with pain extending down the leg, and pain referred to the sides and the back, and it is also accompanied with general nervousness. I recall, now, three cases of sacral neuralgia in which the nerves were tender at their exit on the right side, and the great pain complained of was on the left side.

Absorption and Excretion of Antipyrine.

Dr. A. Mossella (*Gazzetta degli Ospitali*, No. 73, 1887), has employed antipyrine by the mouth, by the rectum, as an ointment, and hypodermically, and has followed up the excretion of it from the body. After the use of clysters (four parts of antipyrine dissolved in one hundred of water), the temperature fell and excretion of antipyrine by the urine occurred. When employed externally, by means of painting with glycerine solutions, inunctions of solutions in almond oil into the arm and knee-joint, etc., no kind of absorption took place. After hypodermic injection into rabbits (one and a half to one and three-quarter grains at a dose) antipyrine could be very quickly detected in the urine. On the other hand, after internal employment of the drug in pathological conditions, he was not successful in finding it in the sputum, pleuritic exudate, or echinococcus cysts. Excretion through the saliva, the skin or the mammary glands could never be observed. Excretion seems to take place only through the urine.—*Deutsche Medizinal-Zeitung*, March 26, 1888.

Action of Calomel Upon the Bile and as an Intestinal Disinfectant.

J. Sawadsky has proved (*Wratsch.*, 1887, p. 17), that calomel possesses a disinfectant action, which results from its transformation into an oxide of mercury under the influence of the alkalies of the bile in the intestine. The coloration of the stools after the ingestion of calomel should be attributed to the biliverdin in excess, which is liberated during this phenomenon of oxidation. This biliverdin is not altered on account of the antiseptic action of the oxide of mercury. These are the reasons why, after the administration of calomel, the reactions of this salt cannot be obtained from the intestinal contents.—*Gazette Hebdomadaire*, March 2, 1888.

Treatment of the Umbilical Cord.

Dr. A. Jacobi, Clinical professor of the Diseases of Children in the College of Physicians and Surgeons, New York, gives the following advice with reference to the treatment of the cord:

"If the ligature be thin, it is liable to cut through the walls of the blood-vessels prematurely; if too thick, it may not suffice to compress them satisfactorily. It ought to be applied at a distance of from one and a half to two and a half inches from the abdominal wall. Not nearer, in order to avoid the effect of the immense muscular power of the umbilical arteries inside the abdominal cavity. A second ligature is placed about an inch from the first, and the cord cut between them. It is a good rule, which must surely be adhered to in every case of thick cord, to apply an additional ligature between the first and the abdominal wall, to avoid hemorrhage from the insufficiently compressed arteries, which may take place after the cord has commenced to shrink. The abdominal end of the cord is then wrapped up in a dry and soft piece of linen, lint, or cotton, placed on the left side of the abdomen, and fastened, by means of a soft flannel bandage, which is wide enough to cover the larger part of the chest and all of the abdomen, so as not to slip.

In wrapping up the end of the cord no oil must be used. Warmth and dryness favor mumification; moisture and exclusion of air, gangrene. This holds good also for the cord when it is separated from the living baby by an additional ligature, and in the dead. Thus, the former forensic axiom, that a dry cord proved life, which prevailed for decades after Meckel had demonstrated its fallacy as early as 1853, is absolutely worthless. Thus, fatty substances, and moisture of any kind, must be avoided as much as possible. Powdered subnitrate of bismuth or oxide of zinc, or iodoform, or salicylic acid, one part with ten parts of starch, may be dusted round the insertion of the cord and over the stump daily. The latter application is not necessarily useless (from the point of view of antisepsis), for the separation of the cord is a gradual one, and not uniform through the whole thickness of the amnion and the three blood-vessels.

The size of sore stump and the rapidity or slowness of cicatrization depend upon the thickness of the cord, the intensity of the line of demarcation, and the reactive inflammation. The latter are most marked in vigorous infants. As a rule, the surface is dry a few days after the falling of the cord, and cicatrization complete within twelve or fifteen days after birth. This normal process is, however, disturbed by careless handling, local irritation, and infectious influences. In these cases there is a serous or purulent secretion, and cicatrization may be deferred for many weeks. Under these circumstances local treatment is required. Carbolic acid ought to be avoided, for the newly-born infant is easily influenced by its poisonous properties. Solutions of lead, zinc, or alum answer quite well. As before, however, I recommend the powders of zinc oxide, bismuth subnitrate, alum with starch, salicylic acid with starch, or iodoform. Such measures will always prove helpful; to omit them in times of erysipelas or diphtheria is unpardonable. Perchloride of iron, or subsulphate of iron, must not be used. Under the hard coagulation formed by its application over the whole wound secretions will accumulate, cannot escape, are absorbed, and produce sepsis. I have seen babies die from applications of iron to the umbilical stump, as I know of women dying for the same reason when the hemorrhages from their uteri or from the lacerated vaginæ were maltreated in the same manner."—*Archives of Pediatrics*, April, 1888.

Specimens of a Case of Oxalic Acid Poisoning.

At the meeting of the Berlin Medical Society, April 11, 1888, F. Strassman presented the specimens from a case of oxalic acid poisoning which exhibited the characteristic lesions with unusual clearness. They were obtained from a man who had hanged himself, and whose body was being dissected; nothing was known of the poisoning. On opening the abdomen, the stomach at once caught the eye through its gray translucent appearance—a condition to which Liman first directed attention, and which led to a probable diagnosis of oxalic acid poisoning. The throat and œsophagus were eaten away, and in the stomach was found a grayish black, greasy mass; the mucous membrane of the stomach was almost entirely wanting. The acid was diffused and had changed the neighboring organs, as is usual when the poison has had time to act. Even the aorta was eaten away and the blood in it compressed into a hard woodeny cylinder. Among twenty-four cases of oxalic acid poisoning Strassman can call to mind none with such far-reaching effects. In the tubules of the kidney were found numerous crystals of oxalate of lime.—*Deutsche med. Wochenschrift*, April 19, 1888.

Case of Optic Atrophy Following Chorea.

Mr. W. G. Sym reports the following case in the *Edinburgh Med. Journal*, March, 1888, and remarks that the case appears interesting, as bearing to a certain extent upon the question of the pathology of chorea.

"G. S., a boy, aged 17, came to the Eye Wards, Royal Infirmary, on 11th of July, complaining of loss of sight in the right eye. His history was as follows: Up till ten years ago he had perfect vision in both eyes; he then, at the age of 7 years, was seized with an attack of chorea, apparently not of a very severe character, on account of which he was admitted to the Infirmary as an in-patient, under the care of the late Professor Sanders. From this affection he made a good recovery, until one morning he felt a sudden mist, as he expressed it, come over the right eye. At the time when this occurred he was not unduly exerting himself, but merely walking quietly down the ward. From that time he has never seen anything with the right eye. He never received any severe blow or other injury in the neighborhood of the eye. In the family history there is nothing particularly worthy of notice. Neither parent is rheumatic, but one brother, a soldier, is said to have suffered from articular rheumatism.

Examination elicited the following facts: Vision—left eye, $\frac{20}{20}$. Right eye, *nil.* No perception of light. When he endeavors to fix a very near object, the right eye does not converge. Right pupil does not contract to light, but does so in sympathy with the left. Tension normal. On examination by the ophthalmoscope, the right eye presented a condition of absolute atrophy of the optic nerve, the disc being of a dead-white color. The blood-vessels, especially the arteries, were extremely small. There were no traces of hemorrhage or exudation, and the disc, in which the cupping of optic atrophy was well-marked, was normally regular in outline. The macula presented nothing unnatural. The choroid coat appeared healthy, and there was no staphyloma. The left eye was perfectly normal in appearance. There were evidences of slight stenosis of the mitral valve—a presystolic mitral murmur being present, and a reduplicated second sound.

Relying on the symptoms and appearances, and on the very clear and emphatic history given by an intelligent patient, I think one is justified in coming to the conclusion that in this case atrophy of the right optic nerve was due to an embolus plugging the arteria centralis retinæ of that side, and thus cutting off the blood supply from the retina, this having occurred during the attack of chorea, at the moment when he felt the sudden mist over the eye. Those which in other cases of optic atrophy are the more usual causes are in this case much more improbable. Simple atrophy, or atrophy following neuritis, almost invariably affects both eyes, though one nerve may be in a considerably more advanced stage of wasting than the other. But here we have a case of absolute atrophy in one eye associated with a normal condition of the other. In children even bilateral simple atrophy is rare, and so also is neuritis, unless dependent on some gross brain lesion.

It is scarcely necessary to indicate the relation which such a case bears to the embolic theory of the pathology of chorea; the accident is, however, a very rare one. Dr. Gowers, in his *Medical Ophthalmoscopy*, states that there are on record only two cases of embolism of the central retinal artery occurring in consequence of chorea; but Dr. Argyll Robertson informs me that a few years ago he saw a precisely similar case—that of a young lady, in whom atrophy of one optic nerve succeeded a severe attack of chorea."

Pregnancy after Ovariotomy.

The Liverpool correspondent of the *Lancet*, March 10, 1888, reports the following unique case. The patient gave birth to her last child in July, 1882, being at that time thirty-five years old. She did not nurse this child. Shortly afterwards, menstruation became irregular, and finally ceased towards the end of 1884, when a small ovarian tumor was discovered. No operation was then recommended, as the tumor was small and movable. She was, however, kept under observation until February, 1887, when the removal of the tumor was considered advisable, and it was accomplished on February 18. A sarcoma of the right ovary was removed. The left ovary, was examined and found to be small, ivory white and indurated, and no suspicion existed in the minds of those who were present that it contained any more ova to mature. It was returned after the examination. Exactly a month after the operation (March 10), the patient menstruated for the first time in nearly three years, and continued to do so regularly on the 18th of each month until August, when she ceased, and symptoms of pregnancy soon after made their appearance. The pregnancy was verified about the end of the fifth month, and up to the present time has run a perfectly normal course, the patient being in excellent health.

—Dom Pedro, Emperor of Brazil, is reported to be dying at Milan, Italy.

THE

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CHARLES W. DULLES, M. D., EDITOR.

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TREATMENT OF ACUTE RHEUMATISM WITH SALICYLATES.

In an article in the *Lancet*, April 14, 1888, Dr. Donald W. C. Hood, physician to the West London Hospital, discusses the treatment of acute rheumatism, with special reference to the use of the salicylates. The paper is based upon a study of over two thousand cases of acute sthenic rheumatism occurring in persons of both sexes, and under thirty-six years of age. The author analyzes this large number of cases in order to demonstrate the comparative results in the case of patients treated specifically, that is to say, with the salicylates, and those treated on general principles.

With reference to the pain due to joint effusion, Dr. Hood thinks there can be no doubt that in many cases patients treated with salicylates experience a marked and rapid diminution or total cessation of pain, and coincidently with this loss of pain there is frequently an equally rapid fall in temperature. Thus, of seven hundred and twenty-eight patients treated with salicylates, five hundred and eighty-two were free from pain within seven days. In another series of cases, numbering five hundred and fifteen, it was found that three hundred obtained complete relief from pain in three days. Forty per cent. of these, however, relapsed, the word "relapse" not being used unless there had been decided return of joint pain, accompanied by a temperature above 100°, the condition lasting longer than twenty-four hours. This relapse often proved to be more intense in the character of its symptoms than the initial seizure; and pain and stiffness of joints after the fever had subsided seemed to be more general among patients treated specifically than among those treated on general principles.

Taking as a basis of comparison the estimate that from fifty to sixty per cent. of all patients with acute rheumatism are likely to have cardiac complications, Dr. Hood finds that the proportion of patients treated with the salicylates who suffer from heart troubles is slightly over sixty per cent. He therefore concludes, from this analysis, that the salicylates have no effect whatever in reducing, preventing, or limiting the intensity of cardiac inflammation occurring during the course of acute rheumatism. This conclusion seems entirely just, though some will doubtless think that fifty or sixty per cent. is an over-estimate of the number of persons suffering with rheumatism and treated without the salicylates who suffer from heart complications; and it might even be believed from Dr. Hood's observations that the effect upon the heart of the use of the salicylates is positively harmful, and not almost negative, as the author states it to be.

Dr. Hood calls attention to the dangerous symptoms which have been found to follow the use of the salicylates, especially furious delirium, ushered in by hyperpyrexia. Bearing in mind the fact that the salicylate of soda is capable of producing delirium and hallucinations in persons unaffected with rheumatism, and that rheumatic patients treated with it are peculiarly prone to delirium, the caution which Dr. Hood urges

should be used in administering this drug deserves to be carefully heeded.

In conclusion, he states that he does not consider the administration of the salicylates to be advisable in the rheumatism of children, but regards it as more especially indicated in the acute sthenic rheumatism of early adult life. In other and older patients they are best given only as an anodyne, and in combination with a more general and tonic treatment. In the acute rheumatic attacks of late adult life, many of which are very like those of gout, he is disposed to give the salicylates as an anodyne. The remedy, he says, seems to be contra-indicated in cases in which relapse follows relapse. In attacks which have been complicated with one of the severer forms of cardiac or pulmonary inflammation, he thinks the evidence indicates that the use of the salicylates should be discontinued, if they have already been employed.

THE DIAGNOSIS OF PERFORATING WOUND OF THE INTESTINE.

At the recent meeting of the American Medical Association, Dr. N. Senn, of Milwaukee, made a very remarkable demonstration, before the Section on Surgery, of a method designed by him for determining the fact and location of perforation of the intestine in cases of penetrating wounds of the abdomen. This method consists in injecting hydrogen gas into the rectum and applying the flame of a match to the point at which the abdominal wall has been perforated; and its usefulness for diagnostic purposes depends upon the fact that a flame of burning hydrogen will appear at the wound in the abdomen in case the intestine has been perforated. In demonstrating this interesting and valuable method, Dr. Senn anæsthetized and shot before the Section several dogs, and then injected the hydrogen, applied a flame to the wound in the abdomen, showed the ignition of the gas, rapidly opened the abdomen, and found the intestine perforated. This was all done with astonishing accuracy and rapidity, and won the hearty applause of all present.

So much would be enough to entitle Dr. Senn to hearty admiration; but his method is capable of accomplishing more. Not only does it furnish a valuable aid to determining whether or not a gun-shot or stab wound has perforated the bowel, and whether or not laparotomy is absolutely indispensable; but it also furnishes a means of finding with comparative ease the number and location of any perforations which may have taken place. Dr. Senn's demonstration showed that, after the presence of a perforation was ascertained, and the abdomen had been opened, the gas distended the bowel to the point of the perforation, and made this easy to find. If there were several perforations, after the lowest one was closed the gas distended the bowel up to the next lowest, and when this was closed, up to the next, and so on until all were closed, when the gas could be detected coming from the mouth of the animal experimented upon.

The whole experiment was conducted with a dexterity and ease which filled the spectators with admiration, and left them impressed with the sureness and simplicity of Dr. Senn's method. In our opinion, the demonstration constituted one of the most valuable contributions to the surgery of penetrating wounds of the abdomen which has ever been made public, and we congratulate Dr. Senn most heartily upon the ingenuity shown in devising the method, and upon the skill with which he presented it to his fellow-members of the Association. It is now the common property of the medical world, and we have no doubt that it will prove to be of great aid to surgeons and a great boon to mankind.

OPERATION FOR ABSCESS OF THE BRAIN.

The illness and death of Mr. Conkling, of New York, has attracted attention to the subject of operations for the relief of abscess of the brain, of which we spoke editorially in the Reporter, April 7, 1888. So far as our information goes, no operation such as we cited at that time as having been done by Mr. Victor Horsley, was done in the case of Mr. Conkling, although there was some reason

to believe that an abscess of the brain had followed a suppurative inflammation of the middle ear. The mastoid process was opened, the operation being followed by temporary improvement in the condition of the patient; but this lasted only a short time, and on April 18, Mr. Conkling died.

This painful occurrence calls attention anew to the importance of appreciating the serious nature of diseases of the ear, and of knowing what operative interference may be undertaken when such diseases appear to have extended to the substance of the brain. There appears to be comparatively little danger to life in opening the skull and exploring the brain for a suspected collection of pus, when this is done according to methods now thoroughly understood by well-informed surgeons; and the development of symptoms pointing strongly to the presence of such a collection after inflammation of the middle ear is sufficient justification for the operation referred to. There are no doubt cases constantly occurring in private practice, in which death might be averted if a surgeon with sufficient courage and skill were summoned to advise, and, if necessary, to act in the case. What has been done in Europe can be done here; and there is no more reason why a man should die here than there, with an undetected and untreated abscess of the brain. On February 23, 1888, Dr. John Ashhurst, at the Pennsylvania Hospital, trephined a woman for abscess of the brain following long-standing ear disease. A small quantity of pus and broken-down brain matter was evacuated, and the patient's symptoms were slightly improved, but she died on the third day. An abscess was found at the autopsy.

Trephining for cerebral abscess has also been practised by several other American surgeons, including Doctors Detmold, Noyes, Nancrede, Pancoast, N. R. Smith and Weed.

MURDOCK'S LIQUID FOOD AND DR. CUSHING.

In the REPORTER, May 5, 1888, we published a short editorial note referring to Murdock's Liquid Food, founded upon certain charges made in regard to it by the *Boston Journal of Health*, and others contained in a letter signed "W" in the *Journal of the American Medical Association*, April 21, 1888. The opinions which we repeated were unfavorable to the food, and contained an intimation which was far from complimentary to Dr. E. W. Cushing, editor of the *Annals of Gynecology*. Since the publication of our editorial we have received information which leads us to believe that injustice has been done both to Mr. Murdock and to Dr. Cushing, and that we owe it to both to acknowledge the fact. So far as the food is concerned, it appears to be an article which has proved of great value in the hands of physicians, and deserves to be judged on its merits. We have received the testimony of a number of medical men to its usefulness, and have been confronted with persons who have received much benefit from using it. So much we deem it right to say—contrary to our custom—in these columns, because we think we have before done Mr. Murdock an injustice.

As to Dr. Cushing, we regret that we have given a sort of sanction to an attack upon him, which we have reason to believe was prompted by unworthy motives, and for which he has been unable to obtain, in the pages of the *Journal of the American Medical Association*, the redress to which he thinks he is entitled.

In another part of this issue of the REPORTER we publish, at his request, a number of letters bearing upon his relations to the Hospital supported by Mr. Murdock. These letters seem to entirely justify his claim that his connection with it was formed with a due regard for the professional opinion of his brethren in Massachusetts, and after due consultation with those who might be supposed to know and voice their ethical sentiments. His position is one which has subjected him to criticism which he could hardly expect to escape; but he has a right to complain that some of it has been unfair and unjust, and we cannot refuse his request for a presentation in the REPORTER of the documents which some of his accusers have gone so far as to insinuate that he could not produce.

Book Reviews.

[Any book reviewed in these columns may be obtained, upon receipt of price, from the office of the Reporter.]

ON A NEW TREATMENT OF CHRONIC METRITIS, AND ESPECIALLY ENDOMETRITIS, WITH INTRA-UTERINE CHEMICAL-GALVANO-CAUTERIZATIONS. By Georges Apostoli, Free Professor of Electro-Therapeutics at the Practical School, etc. Translated by A. Lapthorn Smith, Z.A., M.D., M.R.C.S., Eng., etc. 8vo, pp. 119. Illustrated. Detroit: Geo. S. Davis, 1888.

The impression left on our mind after carefully reading this book is that Dr. Apostoli is an enthusiast. This fact, however, does not make his book any less interesting. The author briefly discusses the nature and etiology of metritis and endometritis. He considers that these diseases are usually caused by an arrest in the process of involution, after labor or abortion. He would limit the use of Faradism to the treatment of subinvolution and the early stage of chronic metritis. This disease in its later stages is treated by intra-uterine galvano-chemical cauterization. The necessary apparatus is described at length, special stress being laid upon the importance of using the galvanometer, the author's clay electrode for the abdomen, and a battery which will furnish a current of 200 to 250 milliampères. The method of operating and the nature of the effect produced are also fully described, and many practical hints are given. The attempt is made to answer objections to the method in advance. The work concludes with an appendix containing, among other things, abstracts of the author's various monographs upon electro-therapeutics. As would be expected of a supporter of an exclusive method of treatment, Apostoli underrates the value of other therapeutic resources. Nor has he presented a method of treatment without disadvantages. Not to mention others, atresia of the uterine canal is a not uncommon result of the cauterizations. Still the book will be useful to those interested in the application of electricity to gynecology.

A COMPEND OF HUMAN PHYSIOLOGY, ESPECIALLY ADAPTED FOR THE USE OF MEDICAL STUDENTS. By Albert P. Brubaker, A.M., M.D., Demonstrator of Physiology in the Jefferson Medical College, etc. Fourth edition, revised and enlarged. 12 mo. pp. 174. Illustrated. Philadelphia: P. Blakiston, Son & Co., 1888. Price, $1.00.

This is an admirable compend of physiology, including enough of anatomy to fit it especially for the use of students of medicine. It has been prepared by one who is fully fitted by his work as Demonstrator in the Jefferson Medical College and as Professor of Physiology in the Pennsylvania College of Dental Surgery, and by his experience as a quiz-master, to compile such a book, and it has proved its utility by the acceptance it has already found. Its style is clear and distinct, its teachings are sound, and it is well suited to the purpose for which it is intended.

THE ESSENTIALS OF MEDICAL CHEMISTRY AND URINALYSIS. By Sam E. Woody, A.M., M.D., Professor of Chemistry and Public Hygiene, etc., at the Kentucky School of Medicine. Second edition, revised and enlarged. Illustrated. 8vo, pp. 140. Louisville: John P. Morton & Co., 1888. Price, $1.25.

This little book is intended for the use of medical students, and presents only the facts of chemistry which are most important to this class of readers. The manner of presenting these facts is plain and terse, and the selection of them is excellent. In the department of analysis of the urine there is a very good account of the methods of conducting a chemical examination, and a number of good cuts illustrate the matters to be recognized in a microscopical examination.

THE SALIVA AS A TEST FOR FUNCTIONAL DISORDERS OF THE LIVER. By Samuel Fenwick, M.D., F.R.C.S., Physician to the London Hospital. 8vo, pp. 78. London: J. and A. Churchill, 1887. Price, 75 cents.

This admirable essay contains one of the most suggestive studies in physiology which we have ever examined. The object of it is to show that the amount of sulpho-cyanide of potassium found in the saliva is an indication of the functional activity of the liver. The author's opinions, which are stated with great clearness and with commendable scientific reserve, rest upon a large number of careful observations, and exhibit an admirable illustration of the inductive method of reasoning. The way in which his investigations were conducted is so simple that any medical man who is not color-blind can easily imitate them, and it ought not to be difficult to confirm or correct his conclusions. It is to be hoped that this will be done soon, and we hope that a number of our readers will get his interesting little book and repeat his experiments, so that we may learn in this country if his suggestions contain—as they appear to—a very valuable theory in regard to nutrition in general, and functions of the liver in particular.

Literary Notes and Queries.

[In this column the Reporter will publish short items of literary interest and questions addressed to this Journal or its readers, and answers to them, in regard to any literary matters: books, authors, places and prices of publications, etc.]

—In accordance with a resolution adopted by the Faculty of Medicine of the University of Pennsylvania, the first number of a sixty-four page medical monthly will be issued October 1, 1888, under the title, *The University Medical Magazine.* It will be edited by an advisory committee of the Faculty, but more directly by Dr. George E. de Schweinitz and Dr. Hobart A. Hare. It will contain original articles and clinical lectures by the members of the Faculty and other teachers in the University. It will also contain reports of the practical work done in the laboratories of the Medical School, the Dental, Veterinary and Biological Departments. The profession will thus receive the current teachings of the University, together will publish items of interest to the undergraduates and reports of the work done in the Medical Societies connected with the Medical School. The price of the magazine is to be two dollars a year. The publisher is A. L. Hummel, Philadelphia.

—The attractive side of "Hospital Life" will be presented in *Scribner's* for June by one who looks at it from a patient's point of view. It contains bits of humerous and pathetic character-sketching. J. Alden Weir, W. L. Taylor, and other skillful artists have made drawings in the New York and Brooklyn Hospitals to illustrate it.

Correspondence.

Dr. Cushing and the Murdock Food Hospital.

The following correspondence is published at the request of Dr. E. W. Cushing, of Boston, who states that he has been refused a similar request by the Editor of the *Journal of the American Medical Association*, after the publication of a letter which reflected very severely upon his professional conduct in connection with Murdock Liquid Food Hospital.

Extract from letter of W. *in the Journal of American Medical Association, April 21, 1888 :* [1]

* * * * In the meantime Dr. Marcy, who had severed his connection some time previously to any thought of the discussion, published in the *Boston Medical and Surgical Journal*, a card stating his previous withdrawal from the Murdock Hospital, and giving as his reasons for so doing that the hospital was not acting up to its agreement, in regard to running and management of the hospital. Immediately, Mr. Murdock replies in the following number of the same journal, contradicting flatly some of Dr. Marcy's statements, and referring to letters of the Council of Ethics of Massachusetts Medical Society, in commendation of the enterprise, which in the next issue of the *Journal*, was flatly contradicted by the Council, thus leaving the way open for Dr. Cushing to show the letter which they claim he has not. * * * * W.

1. DR. CUSHING TO DR. TOWNSEND.

Boston, Oct. 8, 1886.

Geo. J. Townsend, M.D.,
Chairman of Committee on Ethics,
Mass. Medical Society.

Dear Sir :—After my interview with you, on the subject of accepting a position as Visiting Surgeon of the hospital now nearly completed by the Murdock Liquid Food Co., on Huntington Ave., Boston, I visited at your suggestion Dr. Johnson, at Salem, and Dr. Francis, at Worcester, your colleagues on the Committee of Ethics, and laid the matter fully before them, explaining as I did to you, that I was not merely inquiring whether there is anything about accepting the position, which would be a subject for reproof or discipline, but that I was solicitous to know whether considered broadly there is anything in such a connection contrary to the interests and honor of the profession.

As I understood from these gentlemen their views coincided with those you expressed to me, viz.: That there was nothing in holding such a position unethical or subject to discipline according to the laws of the Society. That so far as appears at present, and if the hospital is managed as it should be, and as Mr. Murdock promises that it shall be, there is nothing undignified nor blameworthy in acting as a surgeon to it. That as the case is wholly without precedent and may become a subject of imitation, it is peculiarly incumbent on the medical staff to avoid any appearance of unprofessional conduct. That I must expect considerable criticism and animadversion, which must be met by frankness, and will disappear if my future course corresponds with my present intentions as expressed to the members of the committee.

Remembering that at our interview you said that, if any further doubts or objections should appear to you, you would write to me and hearing nothing from you I have concluded that there is nothing to prevent me from accepting Mr. Murdock's request, and take this opportunity of accepting the position he offers.

I shall have no interest whatever in the company. I shall have full charge of the medical and surgical treatment of patients. I am under no obligation to use the "food" for the patients; but I can have it fresh, and gratis for them, and propose to give it a fair trial. I am at liberty to give instruction to post-graduates, I have no connection with the homœopaths, who have rooms under the same roof but with no communication, and with entrance on another street. I have nothing to do with the advertisements and financial management of the hospital. Nevertheless, Mr. Murdock has seen his way to modify his advertisements in consideration of the susceptibilities of the profession, as you will see by referring to the later numbers of the *Boston Med. and Sur. Journal.* In short, my duties are to be similar to those of the professional editor of a medical journal owned by a commercial firm. My name is not to be used in advertising, in any lay journal especially not.

Under these circumstances Dr. Henry O. Marcy has consented to act as consulting surgeon, and I expect that other well-known members of the profession will similarly accept. We propose to give a course to physicians beginning next January.

This then, Mr. Chairman, is the programme as proposed, and I bespeak for it your favorable opinion. I fully realize the importance of discretion in the management of this mat-

[1] W. is said to be Dr. Geo. W. Nash, formerly assistant to Dr. W. O. Marcy.

ter, which may have imitators in these days of innovation. I also, however, fully believe that such an agency for good or evil should be properly guided and made a convenience to the profession as well as to the public, instead of letting it fall into the hands of irregulars or unscrupulous medical men.

If at any time you observe anything connected with my functions at the hospital which seems to you contrary to the dignity of the profession, I pray you to advise me of it fraternally and I will try to remedy it. In conclusion, let me add that Mr. Murdock feels, and states with emphasis, that his object in supporting this Hospital is not solely a commercial one, but that he has fully his share of philanthropic motives and a desire to be useful, such as influence medical men in giving their time and work to hospital service. Yours respectfully,

ERNEST W. CUSHING.

2. DR. TOWNSEND TO DR. CUSHING.

South Natick, Oct. 16, 1886.

Ernest W. Cushing, M. D.,

Dear Doctor:—I duly received yours of the 8, and press of business has delayed my answer, which I have not regretted, as I have no objections to urge against your plans. Your propositions all represent correctly the opinions of the Committee on E and D (Ethics and Discipline) as far as I have had opportunity to learn them. I had a conversation with Dr. Johnson at the meeting of the Council. Dr. Francis was not present, you have stated his views correctly. As to the policy of assuming your position, it is not for us as a committee to decide, and, as you suggest, the idea is so new that for one I do not feel competent to advise. I have read Murdock's last advertisement and there is nothing in it that is in the least objectionable. Plenty of the members of our Society use the food, and it is advertised as a food, and not as a medicine.

Farther, I see no reason why we should deny to him all philanthropy, even if at the same time he advances his own interests.

Trusting that your experiment will prove successful, profitable and agreeable and with kind remembrances to Dr. Marcy, I am yours very sincerely, GEO. J. TOWNSEND.

3. DR. CUSHING TO DR. TOWNSEND.

Boston, Oct. 20, '86.

Geo. J. Townsend, M. D.,

Chairman of the Committee of Ethics and Discipline, Mass. Med. Society.

Dear Sir:—Your favor of the 16th inst. was duly received, and contents noted with much pleasure. I thank you very much for the good will and moral support expressed in your letter, and assure you that I shall do everything in my power to continue to merit your confidence.

Dr. Marcy thanks you for your remembrance, and desires me to express his kind regards to you. I believe that Dr. Henry J. Bowditch has consented to act as consulting physician to the hospital.

Yours sincerely,

E. W. CUSHING.

(In the correspondence furnished us, there follows here a letter—No. 4—from Dr. Marcy, dated Feb. 15, 1888, and one from Mr. Murdock—No. 5—dated Feb. 24, 1888, which have already been published in the *Boston Med. and Surg. Journal.* We do not reprint them, for want of space.)

6. DR. GOSS TO THE BOSTON MEDICAL AND SURGICAL JOURNAL.

BOSTON, March 12, 1888.

Mr. Editor:—Owing to correspondence published in the *Journal* of the 1st inst., the Committee on Ethics and Discipline desire to make the following statement:

Shortly before the Councillor's meeting in October, 1886, Dr. E. W. Cushing called upon three members of the committee separately, and asked for a formal opinion as to the propriety of his accepting the position of surgeon to the Murdock Liquid Food Hospital. Each member declined to express an official opinion, but each stated his views. October 8, 1886, Dr. Cushing addressed a letter to the Chairman of the Committee stating his relations to the Hospital, but he did not request action by the Committee.

The Committee had never been asked to consider the subject, and they desire to say that if asked, they could not have done so without exceeding to powers delegated to them. Very respectfully,

FRANCIS W. GOSS, M.D.,
Secretary.

—The *Chemist and Druggist*, May 12, 1888, states that the German authorities officially notified the officers of the Strasburg Medical Society, on April 30, that the society had been dissolved, and forbidden to meet again under penalty of fine and imprisonment. The reasons for this suppression are unknown, as the men composing the society were of high rank in the profession, and politics were rigidly excluded from it. The German government never showed by word or sign that the society had incurred its displeasure.

Notes and Comments.

A Home for Physicians.

At the recent meeting of the Alabama State Medical Association, April 10, 1888, Dr. Edward H. Sholl, in his Presidential address, proposed the founding of a Home or Retreat for aged physicians, or the widows or orphans of physicians. In explaining his idea, he said: "I mean distinctly some ample provision by which some Home or Retreat shall be erected, which shall be the property of and the care of the Medical Association of the State of Alabama, where in the years to come, as annual contributions, endowments and legacies come in, shall be gathered, for instruction and comfort, not only the orphans of our brethren with all the appliances for preparing them to deal with the practical issues of life, but also the widowed, who by the payment of a moderate sum, if able, or by gracious beneficence, if not, shall find such a welcome shelter for a time, or life, if needs be, as shall make the burdens and sorrows of life more readily borne, and brighten the infirmities of advancing years that would otherwise be lone and cheerless.

"Here also the superannuated of our profession, either infirm from the weight of years or bodily affliction might come, those without kith and kin, but with a moderate income to provide for themselves the luxuries of a comfortably appointed home with congenial surroundings, and give themselves over to the rest they have well earned.

"Here, too, might come those of our number, worthy, upright men, sick, homeless, penniless, almost baffled by adverse fortune, to seek rest and renewing of health, made freely welcome by the rich bounty of others to those comforts long denied them, to go out again refreshed and reinvigorated to the duties of life, or to find tender hands to nurse, tender sympathy to watch the decline of life, and at last to close the sightless eyes and fold the cold still hands upon the breast of another way-worn pilgrim, who has reached his journey's end."

"Analgesine."

Antipyrine, says the *Chemist and Druggist*, May 5, 1888, is hereafter to be known and dispensed by the Central Pharmacy and all the Paris hospitals under the name "analgesine." At a recent meeting of the Academy of Medicine of Paris, Prof. Bourgoin announced this fact, and expressed the hope that all physicians in civil practice would follow the example to thwart an oppressive monopoly. His remarks were greeted with great applause. This action is in accordance with a decision of the director of the Paris *Assistance Publique*, that henceforth prescriptions calling for antipyrine shall be filled by the Hospitals' Central Pharmacy with analgesine or dimethyloxyquinizine.

A Dangerous Prescription.

The *American Druggist*, April, 1888, says: The following prescription was presented to a friend of one of our correspondents:

℞ Antipyrini.....gr. 15
Spir. æther. nit.....fl. ʒ 2
Tr. aconit. rad.....gtt. 8
Syr. lactucarii.....q. s. ad....fl. ʒ 2
M. et signa: Dose: One teaspoonful.

This prescription was prepared and produced a green solution, and one teaspoonful was given to a patient, a little boy of five years of age, and who was not by any means sick or confined to his bed, but seemed to be ailing with a little fever. After taking the first teaspoonful, the child was thrown into convulsions, and died in about two hours.

In explanation of the reaction taking place between antipyrin and spirit of nitrous ether, we would state that the incompatibility of the former with nitrous acid or nitrites, in presence of acids, has long been known. In fact, the reaction has been used both as a test for nitrous acid as well as for antipyrin.

In dilute solutions containing nitrous acid, antipyrin causes a bluish-green coloration. In concentrated solutions it produces a precipitate of bluish-green crystals, consisting of *iso-nitroso-antipyrin*.

Now, it is well known that nitrites in general are active poisons. Even small doses of an alkali nitrate, for instance nitrite of potassium or sodium, say 5 to 8 grains, produce a throbbing and a sensation of bursting in the head, with vertigo, eructations, nausea and vomiting, cyanosis, and often convulsions. Free nitrous acid is still more energetic, even in very small quantities. The new substance produced by the reaction between antipyrin and spirit of nitrous ether appears to belong to that class of bodies in which the effect of the presence of an active radical is greatly intensified. Yet neutral nitrites do not produce the above-mentioned reaction with antipyrin. It is necessary that the nitrous acid be in a free state. If this is the case, the bluish-green or pale green color will appear on the addition of a solution of antipyrin. When this color is once developed, it is not destroyed or removed by the addition of an alkali. But if the free nitrous acid is first neuralized with an alkali, the addition of antipyrin will fail to produce any color reaction.

Experience Among Russians in the Treatment of Small-pox.

Reimer (*Archiv für Kinderheilkunde*, Bd. ix. H. 1.) says his experience includes the treatment of thirteen hundred cases. When the pustules were covered with Weidenbaum's ointment (consisting of mercurial ointment, soap, and glycerine) they developed rapidly, but very painful irritation resulted, and the febrile process was not shortened. With a solution of India-rubber the children complained of great burning, and in four cases septicæmia resulted. Nitrate of silver applications seemed only to make the scars deeper. Hebra's iodine bandage caused great pain. The pustules became confluent in great scabs, which soon fell off, but the application had slight influence in respect to scarring. In forty-six cases applications of sublimate were made with great care. A mask was moistened with a solution of 1 to 500, and applied to the face four times daily for periods of ten minutes each. The development of the pustules was hastened thereby, but there was no perceptible influence upon the scarring process.

Schwimmer's paste of carbolized oil was found difficult of application upon a mask. A paste was then made from carbolic acid, talc, chalk, and starch, and applied four times daily in seventy-seven cases. The results were unfavorable. In thirteen cases there were symptoms of carbolic acid poisoning; in twenty-six there was nephritis, and in seven hæmaturia. Burkhardt and Zulzer's treatment with xylol was tried in fifty-two cases without any effect as to the scars. Other methods were equally unsuccessful. Salicylic acid was then tried in fifteen cases, as recommended by Schwimmer and Claridge, five grains being given every two hours, and in all the cases the duration of the disease was shortened. Microscopical examination of the blood in the early stages of the disease showed that after six days' treatment with salicylic acid the rod-like bacteria which had previously been found had disappeared.—*Archives of Pediatrics*, April, 1888.

Plea for Small, Frequently Repeated Doses.

Dr. Charles C. Partridge, of Kansas City, says when he first started out in medicine he hooted at the idea and doubted that a minim dose of ergot repeated every hour would have a contractile effect upon the womb and that it would control a hemorrhage from that organ, until he was led to try it. A minim dose of tincture of aconite repeated every hour or two will frequently cut short an attack of capillary bronchitis or pneumonia in children. No less an authority than Sidney Ringer claims this, and yet we know that often it is prescribed in larger doses, although it is a powerful cardiac depressant. Who, he says, has not witnessed the wonderful effects of this drug in minim doses in cutting short an attack of quinsy? A minim dose will act just as well in the latter case, repeated every hour, as three or five minims will. If anyone doubts it, he advises him to try it and be convinced.

Ten years ago, he says, we thought that it was absolutely necessary to give from five to ten grains of calomel in order to get good cathartic effects from this drug, and yet we can get just as satisfactory results to-day from the 1-20 of a grain repeated every hour as we can from giving five or ten grains.

Again, take the new and valuable drug, antipyrin, ordinarily prescribed in fifteen grain doses every two to three hours until the temperature falls. He says he recently, in a case of acute articular rheumatism, gave eight grains three times a day, and obtained toxic effects, although the patient's suffering was allayed, but found it necessary from the photophobia and other symptoms of disordered vision to reduce this dose to four grains at night, when these symptoms disappeared. In fever, no matter of what nature, one grain every three hours will produce very soon a slowed pulse and copious diaphoresis. He says his experience justifies the statements made.—*Kansas City Medical Index*, March, 1888.

Resorcin in Some Gastric and Cutaneous Disorders.

Dr. Edward Mackey, in a communication on this subject in the *Lancet*, March 24, 1888, reports seventeen cases of gastric ulcer or catarrh, presenting varying degrees of chronicity and severity, of which he has retained sufficient notes to justify a conclusion. They were all women except one. Most of them had taken, at various times, bismuth, prussic acid, alkalies or acids, rhubarb, etc.; and one of them—a woman at the climacteric—failed to attribute decided benefit to the resorcin, and to ask for it again. He has met with no drawbacks from its use, such as causing pain, vomiting or constipation; in a few cases, however, when giddiness which occurred might have been due to it, he has lessened the dose to three grains; the usual one was from four to five grains in one tablespoonful of chloroform water, to which plain water would be added.

Small-pox in the United States.

Surgeon-General John B. Hamilton, of the U. S. Marine Hospital Service, reports, sixty cases and four deaths from small-pox in Philadelphia up to April 18; of seventy-nine cases in New York up to April 19; of forty-three cases and seven deaths in Brooklyn up to April 20.

Treatment of Laryngitis.

The London correspondent of the *Canada Lancet*, April, 1888, says that Dr. Wolfenden, of the London Throat Hospital, in cases of sub-acute laryngitis prescribes the following:

℞ Tinct. benzoini co.,.....f℥iv
Sig.—A teaspoonful in a pint of hot water for each inhalation, night and morning.

The patient is cautioned not to go out of doors for at least half an hour after using the inhalation. Trochees of krameria are also ordered, each lozenge containing one or two grains of the extract of rhatany.

In some cases the following vapor is preferred:

℞ Olei eucalypti.....f℥ij
Magnes. carb. levis, grs. lx;
Aquæ ad.....f℥iij
To be used in the same manner as the above.

In chronic laryngitis, in addition to any constitutional treatment which may be required, he usually prescribes the following vapor:

℞ Olei pini sylvestris.....f℥ij
Magnes. carb. levis, grs. lx;
Aquæ ad.....f℥iij
Sig.—A teaspoonful in a pint of hot water for each inhalation, night and morning.

He also gives trochees of krameria.

In tuberculous laryngitis he prescribes a vapor of benzoin and chloroform, as follows:

℞ Tinct. benzoin co.....f℥j
Chloroformi.....m℔iv
Put in a pint of hot water for each inhalation.

As a local application he uses solutions of lactic acid, varying in strength from twenty per cent. to sixty per cent., applied by means of a brush, twice a week. In granular pharyngitis he finds the galvano-cautery the most satisfactory treatment.

Pasta Mack.

Pasta Mack is a new toilet preparation which dissolves in water with evolution of carbonic acid gas, and is said to produce an agreeable and refreshing effect upon the skin. According to Eckstein in *Berliner Pharm. Zeitung*, it is composed of a mixture of 27 parts rice starch and .73 parts effervescing powder (bicarbonate of sodium 10, tartaric acid 9), suitably perfumed and formed into small tablets. The perfume imparted to the water is strong and agreeable and remains upon the skin long after washing.—*Am. Journal Pharmacy*, May, 1888.

Abscess of the Liver; Operation; Recovery.

Dr. G. A. White reports the following case: Chas. C——, 38 years old, a miner, was admitted to the Sacramento County Hospital, Nov. 19, 1887, suffering with abscess of the liver. His primary illness dated from December, 1886, eleven months previously, when, from the history given by himself, he must have had an attack of malarial hepatitis. The patient presented a bronzed appearance, was greatly emaciated, had high fever, and was profoundly exhausted on account of his railroad trip from a neighboring county. Liberal doses of quinine and whiskey with morphine hypodermically were given for two days, when sufficient reaction had taken place to warrant operative interference. The borders of the sac were tolerably well defined, the abdomen was prominent, about as large as a woman's abdomen at the eighth month of pregnancy. The upper border of the sac crowded up the diaphragm, so that respiration was attended with difficulty. Fluctuation could be detected in the lower intercostal spaces, as well as over the right half of the abdomen. Selecting a point at the ninth intercostal space, the abscess was opened by an incision about one and a half inches in length, and two gallons of pus discharged. The cavity was freely irrigated with warm carbolized water, a large drainage-tube was inserted, and an oakum dressing completed the operation. The after treatment consisted of irrigation of the sac twice daily for two weeks, and afterwards but once a day, with a solution of boracic acid (one drachm to one pint of warm water). The large drainage-tube was replaced with a double tube of smaller size. Later on, a single tube was used as long as pus discharged. When the discharge became serous the wound was kept open with a tent of saddler's silk, until finally the discharge ceased altogether. Opium pills were given when necessary, for a few days after the operation. The patient was put upon a milk diet with milk punch, and gradually fed up to a full diet; little medicine, other than tonic doses of quinine and iron, was needed in the treatment. The patient made a complete recovery, and was discharged cured February 3, 1888.—*Sacramento Medical Times*, April, 1888.

Electrolysis in Stricture of the Rectum.

At the meeting of the Baltimore Academy of Medicine, March 6, 1888, Dr. S. T. Earle reported the progress of a case of stricture of the rectum from syphilis, which he was treating by electrolysis. This treatment was necessarily slow. The patient had had the stricture six or seven years, and had been operated on two years ago, when linear proctotomy was performed, which was not followed by dilatation, and so it grew up tighter than before. It was the worst case Dr. Earle had ever seen. On introducing the little finger into the rectum he could not even feel the indentation at the point of the opening. He succeeded in introducing a small silver probe. She was able to have fluid stools, but only with straining. His first intention was to do linear proctotomy, but concluded to use electrolysis as a matter of trial. He used a Barrett battery, introducing the electrode with steady pressure, without force, for ten to fifteen minutes, and using ten cells. This was done at first once a week, and the opening grew larger as the size of the electrode was increased. He had so far eight sittings, and on the day of making his report he had introduced a bougie, two inches in circumference at the large end, almost all the way in. There was less straining and little pain now, and the stools were partly solid. There was a neoplasm in Douglas's *cul-de-sac*, and this was being absorbed by the current. The positive pole was placed over the abdomen, and not on the buttocks. He was very much pleased with the progress thus far, and will report future progress. In answer to Drs. Uhler, Ashby and others, Dr. Earle stated that a sitting generally lasted from fifteen minutes to half an hour. The negative pole was in the stricture, and the irritation and pain from it soon subsided. He had used as high as fifteen cells with the largest electrodes.—*Maryland Medical Journal*, March 24, 1888.

Results of Mechanical Treatment of Hernia.

In the *N. Y. Med. Journal*, March 3, 1888, Dr. W. B. DeGarmo gives an analysis of one thousand cases of hernia occurring in private practice, and the results of mechanical treatment. In concluding his article, he says that out of the entire number of hernias, 1,203, a little over one-quarter (or 336) have been cured, and, as shown by the table, 463 were improved, 312 were retained, 5 were abandoned as unmanageable, and in 87 the result was unknown.

The study of the foregoing cases, he says, leads to the following conclusions:

1. That by early mechanical treatment a large percentage of hernias occurring under middle age can be cured.

2. That, while there is no intent to underrate the value of surgical measures in suitable cases, it is believed that the greatest relief to the greatest number can be afforded by the more careful and scientific mechanical treatment of hernia.

3. This end can be attained only by the personal attention of the practitioner, instead of allowing such cases to go into the hands of unprofessional and incompetent persons.

Venesection in Puerperal Eclampsia and Pneumonia.

Dr. Hiram Corson, in a letter to the *Medical Standard*, April, 1888, says: I have greatly deplored the fatality which has resulted from the treatment of this affection by or with the various depressants in lieu of venesection which in these cases is not a depressant but a reliever of depression. It brings just such relief to the patients as the removal or elevation of a portion of depressed bone by a surgeon brings to the patient who lies unconscious before him. In all the cases which I have seen in over fifty-nine years' practice, I bled freely—sometimes ferociously, pardon the word—and all recovered. Still more frequently have I averted the convulsion by a timely bleeding when the symptoms heralded the coming of convulsions.

What crowds of women have been lost by the physician who waited for the slow action of potassium bromide, chloroform, veratrum viride, aconite, ether, etc., etc. It is horrible to have men who have seen a patient bled, teaching that "no one has any blood to spare," "that it is a murderous practice." Pretty teachers they are! They do not even know the effects of the agents which they praise. Many of our medical teachers know nothing of general practice. They are filled with hospital notions; one of which is, that nearly all diseases are the result of syphilis, and on that opinion they base their treatment.

Important as is this subject, there is another which is of equal importance; the treatment of pneumonia. Under the old "murderous" treatment it was one of the most manageable of diseases, yet it now sweeps off people by scores. I would be ashamed to lose a patient, old or young, ill with this disease. Yet teachers, scared by homœopathic assailants of venesection, blatantly denounce a practice they have never witnessed, and as blatantly praise poisons which are useless in small doses and dangerous in those which give rise to their specific symptoms.

Experiments in Implanting Teeth.

Dr. Younger, of San Francisco, has demonstrated that it is practicable to replace lost teeth, even after the socket has been filled up with bony substance. He simply drills into the jaw, gouges out a new socket, and then, taking a foreign tooth that has long been extracted, cleans it thoroughly, soaks it in bichloride of mercury and inserts it in the socket thus artifically formed. Describing this process, *Science*, March 23, states that Dr. W. M. Gray, the microscopist of the United States' Surgeon General's office, has examined a tooth which had been implanted by Dr. Younger's method and then extracted. Dr. Gray's microscopical examination shows beyond question that the tooth so implanted is actually revived, that circulation is established between the socket and the implanted tooth, and that the socket takes an active part in anchoring the tooth. Dr. G. M. Curtis, of Syracuse, N. Y., has successfully repeated Dr. Younger's experiment, and found that a tooth which he had implanted was so firmly anchored that it broke when he was extracting it. As good teeth are indispensible to proper mastication, and hence to nutrition of the body, the discovery of means for replacing them when lost is a very valuable contribution to dentistry.

Molasses in Conjunctival Affections.

Dr. Henry F. Wolfner, says: "About one year and a half ago, I was told by several practitioners who attended the Post-Graduate School, that there had been a traveling eye doctor in their neighborhood, who was very successful in the treatment of chronic conjunctival inflammations; the remedy he used looked like molasses and tasted sweet. Knowing that sugar had been used, at least in the lower animals, in interstitial corneal infiltrations with considerable success, and that it was still sometimes applied to granulating ulcers for its slight caustic effect, I classed molasses with the other irritants, and made up my mind to see if there was any special virtue in this new medicament. It has now been used in almost every case of chronic conjunctival affection that I have seen at the clinic, and for the last year I have also used it in private practice. My observations lead me to believe that it has some special virtue, as cases which had formerly been treated with sulphate of copper, nitrate of silver and jequirity unsuccessfully, almost immediately commenced to get better under its use. Most good has been accomplished in those chronic cases, in which although the granulations have become flat, the pannus the result of the granulations, has not disappeared. According to the amount of stimulation the eye will bear, the instillations are made every day, every other day, or only once or twice a week. The mode of application is very simple; a small quantity of molasses is taken up on a probe and allowed to drop into the everted, lower, retrotarsal fold of the conjunctiva."—*St. Louis Courier of Medicine*, April, 1888.

Cancerous Uterus Completely Removed by Chloride of Zinc.

At the meeting of the Clinical Society of Maryland, March 2, 1888, Dr. B. B. Browne exhibited the specimen from this case and stated that the patient was thirty-five years of age. She had suffered from all of the symptoms of cancer, viz.: Pain, hemorrhage, etc. He attempted to treat the cancerous mass with chloride of zinc. Previous to its use he had curetted the tissue and had used the thermo-cautery. The chloride of zinc was then applied in a saturated solution by means of tampons. These were protected by absorpent cotton, and below this another tampon was placed, saturated with bicarbonate of soda and vaseline. On the seventh day the tampon was removed, and on the tenth day the uterus sloughed and came away. There was no rise of temperature at any time. The patient suffered considerable pain which was controlled with morphine hypodermically. At this time the patient is going about and there is no evidence of any return of the cancer.

Dr. W. P. Chunn asked Dr. Browne if it had been his intention when he began treatment to remove the uterus in this unique way, and also if he would recommend it in the treatment of a similiar case. Dr. Browne replied that he did not expect to remove the whole uterus in this way when he began the treatment. Its success in this case would seem to recommend it favorably for further trial.—*Maryland Medical Journal*, April 7, 1888.

Oil of Peppermint as an Antiseptic and Remedy in Phthisis.

W. Leonard Braddon reports in the *Lancet*, March 24, 1888, very encouraging results from the employment of oil of peppermint as an antiseptic, and as a remedy in phthisis and diphtheria. In phthisis he employed the drug by inhalation, while in diphtheria it was freely and copiously applied to the diseased surfaces twice daily.

NEWS.

—Dr. James Orr, a prominent dentist in Pittsburg, committed suicide May 16.

—A new ward for the Massachusetts General Hospital, to be devoted to abdominal surgery, has been begun.

—Professor Wroblewski, of Cracow, has recently died of blood poisoning, which he suffered as the result of an experiment in the lecture-theatre.

—Dr. Engelhardt, of Halle, has been appointed Professor Extraordinary of Gynecology at Jena, in place of Professor Küstner, who has gone to Dorpat.

—St. Agnes' Hospital, in Philadelphia, was dedicated and formally opened May 16. It is under the care of the Sisters of Charity, and will accommodate 300 patients.

—Professor Lichtheim, of Berne, has accepted the position of Director of the Medical Clinic at Königsberg. He succeeds Professor Naunyn, who has gone to Berlin.

—Dr. Howard Pinkney, a graduate of the College of Physicians and Surgeons of New York, class of 1860, died May 14, while in a railway train in England, whither he had gone to improve his health.

—A Vienna correspondent, says the *Chemist and Druggist*, May 5, 1888, reports that chemical analysis of the Carlsbad water known as the "sprudel," has established the fact that it contains gold. Possibly the spring from which the "sprudel" is drawn must in its course have become combined with a subterranean well which has passed through a gold-bearing stratum.

—The *Lancet*, May 5, 1888, states that Dr. John McIntyre has had a Union Club building erected in the grounds of the University of Glasgow. The building contains a library, a hall for debates, a dining-room, convenient committee rooms, and every arrangement for a perfect house of its kind. It cost about twenty-five thousand dollars.

—A committee of the Board of Overseers of Harvard College at a recent meeting, reported in favor of prohibiting all intercollegiate contests, and the placing of the supervision of athletic exercises in the university itself under the control of a committee in which the faculty shall have a stronger influence. A minority report submitted by Dr. Walcott advised that the formal intercollegiate contests be limited to Yale, and should take place only at New Haven, or Cambridge, or some other New England city or town. The Board of Overseers decided substantially in favor of the minority report.

HUMOR.

True to his Motto.—Patient—"Then you think its all up with me, doctor?" Doctor—"I'm afraid so." P.—"Well, we must all die once, and I may as well go now as afterward. You're sure I'm going?" D.—"Yes."

P.—"Then let me have your bill."

D.—"My bill! My dear sir, this is very unusual. You should give your thoughts to more serious matters."

P.—"My motto has always been 'pay as you go,' and now that I am going I want to pay."

So he paid and went.—*Boston Courier.*

A Growing Child.—Conductor—"Madam, did I understand you to say this girl is not yet twelve years old?" Mother—"She will be twelve next spring." "And you want to go all the way to New York in this car?" "Yes." "Then you should not go on this train." "Why not?" "Because this is a slow train, and if that girl keeps on growing as she has been, by the time we get to New York she will be so large that she will not be able to get through the car door. The company can't afford to take the car to pieces on a half-fare ticket."—*Texas Siftings.*

Bright Literary Prospects.—Friend (to young writer)—"What do you hear from the *Every Other Monthly Magazine*, Charley, in regard to your MS.?" Young writer—"It came back to me a day or two ago with 'many thanks of the editors for my kindness in giving them the privilege of seeing it.' Mind you, Gus, not the thanks of a single editor, but the thanks of every one of 'em on the magazine, and there may be a dozen for all I know. I tell you, Gus, that was a great article, and I'm going to send them something else in a few days."—*The Epoch.*

Thrilling Adventures with the Indians.—Omaha Dame—"You have lived in the West many years, you say?" Domestic—"Yes, ma'am, I crossed the plains with a family many years ago, and was captured by Indians. They was a lazy set o' vagabonds, and made me do all the cooking for 'em." "Dear me! How did you escape?" "I didn't escape, ma'am, as long as there was one of the tribe alive, but at last there was none left and I got away." "Were they killed by the soldiers?" "No, ma'am. The agency doctor in whose family I worked afterward said as how he thought they died of dyspepsia."

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Clinical Lecture.

HÆMOPTYSIS: CONSECUTIVE TUBERCULOSIS.

A Clinical Lecture[1] delivered in the Hôpital Pitié,

BY PROFESSOR S. JACCOUD,

MEMBER OF THE FACULTY OF MEDICINE, AND OF THE ACADEMY OF MEDICINE, PARIS, FRANCE.

Gentlemen:—For thirty years I have defended Morton's theory of phthisis by hæmoptysis; I have shown from my own personal observations that the causal influence of hæmoptysis on the development of tuberculosis is explicable by my doctrine of pulmonary *hypotrophy;*[2] and I have reported in my *Clinique de l' hôpital Lariboisière*, as well as in my "Curability and Treatment of Pulmonary Phthisis," numerous cases which prove clearly this relation of cause and effect between hæmoptysis and tuberculosis.

But however convincing they may seem to be, none of these observations equal in precision, in demonstrative value, that which is the subject of my lecture to-day; here the causal influence of hæmoptysis is put beyond the shadow of a doubt, and what is more, the autopsy has confirmed this etiological judgment in a striking manner.

A robust man, 48 years old, a painter, came under my care, in ward Jenner, No. 7, on the fifteenth of December, 1886. I showed him to you the next day, and I presume you have not forgotten his appearance or the train of symptoms which he presented. Lying in a state of prostration, his eyes half closed, his complexion one of complete pallor, you noticed how shallow and frequent was his respiration, how rapid, small and indistinct was his pulse, and by the head of his bed you remember there were two spittoons full of bright red blood, which had been expectorated during the latter part of the night, and especially since three o'clock in the morning. We learned that for four days he had raised blood of the same quality repeatedly and in great quantities. The blood was rusty, frothy; it had been ejected during violent attacks of coughing. There was no doubt as to his condition, the diagnosis was plain; it was a case of hæmoptysis, whose onset dated back four days, to the 12th of December.

The hemorrhage which caused the hæmoptysis certainly did not originate in the pulmonary parenchyma. Pulmonary hemorrhage indeed, whether in focus or infiltrated, gives rise to an expectoration of black, non-ærated blood, composed generally of distinct sputa. One glance at the blood raised by our patient was enough to lead us to reject this hypothesis, and I have only alluded to this contingency in order to freshen your memories.

The hemorrhage which produced this hæmoptysis, then, had its seat in the bronchial tubes; it was a bronchorrhagia, and if the blood expectorated perfectly retained the character of arterial blood, it was because it was voided as it had been effused into the bronchi. Granting this as to the seat of the hemorrhage, what was its source? From what vessels did it come? On account of its bright color it could not have come from one of the pulmonary arteries; it must have been one of the bronchial arteries, or pulmonary veins, which had given way. Between these two possibilities we could not pronounce positively from the character of the blood. We shall soon see that the study of the case will warrant a conclusion which is at least probable.

[1] Translated by Kate C. Hurd, M.D.

[2] A state of under nutrition of the lungs, insisted upon by Jaccoud as a condition existing before phthisis.

Hæmoptysis by broncorrhagia—such, then, is the symptomatic diagnosis; to this first stage of judicial inquiry should succeed the pathogenic diagnosis. What is the cause of this hæmoptysis? The prognosis, the nosological significance, in a word the medical diagnosis, depends on the reply to this question. The solution is often difficult; in order to obtain it with certainty, you should always conform to the method which you have seen me apply in the case before us. The process is as follows: 1. Ascertain the state of the lungs. 2. Determine the conditions under which the hæmoptysis appeared. 3. If the examination proves the existence of any lesion in the lungs, determine the chronological relation between this lesion and the hæmoptysis.

Our first point then is to ascertain the condition of the lungs. On examination we find the right lung sound; as for the left lung, it is equally sound in front, but behind, at the median part, a little below the spine of the scapula, in a limited area no larger than the palm of the hand, I have discovered since the admission of the patient a focus of moderate dulness and of fine sub-crepitant râles. In the next placé, we want to determine the condition under which the hæmoptysis appeared. The conditions possess a strange definiteness in this case. November 12, the Sunday before his admission to the hospital, this man being in perfect health, ran rapidly for several minutes in order to overtake an omnibus; just at the moment, when, having nearly reached it, he was stretching out his arm to grasp the railing of the the omnibus, he was suddenly seized with a violent fit of coughing and immediately on the spot he raised a great quantity of bright red blood, like that which we have this morning seen in the spittoon.

By the time he had returned to his home the hæmoptysis had ceased. On Sunday evening he had a second attack, then another on Monday, and so on each day, until he entered the hospital, Wednesday, December 15. During the interval between Sunday and Wednesday, a fever set in, for his temperature on entering was 101°.3 F., the next morning, it is true, it was only 100°, but that evening it mounted to 102°.9. In fine, the hemorrhage as you see was caused by the exertion of rapid running.

The third point is to determine the chronological relation between the lesion in the lungs and the hæmoptysis. This relation is very clear. The hæmoptysis appeared suddenly while the patient was in a state of perfect health; it was then the primary incident; the lesion in the left lung and the fever are secondary effects. This inquiry brings us then to the following diagnostic conclusion: hæmoptysis following a violent muscular effort or strain in an individual whose respiratory apparatus was healthy. But this conclusion, perfectly justifiable though it may be, since it is the simple expression of the facts, is evidently insufficient; there must have existed in this man some other condition which caused his exertion to bring on a hemorrhage. What was this condition?

Must we admit a tuberculosis, totally latent until the very moment of his unfortunate run? Everything negatives this assumption. This man has never had a cough, nor has he ever had any disease of the respiratory organs; his health was in no way changed during the months preceeding the accident; and, moreover, his family antecedents are all right: his brother, sister and children are in excellent health; finally, if we found in the median lobe of the left lung the focus of râles, which I pointed out to you, weare none the less certain that the apices are quite sound. Under these conditions, latent tuberculosis is not merely improbable, it is an impossibility.

From this we are now led to the inquiry whether the condition which rendered his exertion a generator of hemorrhage may not be connected with the circulatory apparatus, although, *a priori*, the character of the blood expectorated scarcely justifies the idea of a hemorrhage of cardiac origin.

The examination shows a cardiopathy, constituted by aortic stenosis and insufficiency, with atheroma of the thoracic aorta. This evidently old lesion had never given rise to any symptom, and it was a profound surprise to the patient to see us inquiring with so much minuteness into all the circumstances of his previous history in order, if possible, to discover some cause for an affection of the heart from which he himself had never experienced the least effect. This search, however, remained of no avail, and we are still in complete ignorance as to the origin of this heart lesion, which may have been a congenital malformation.

However this may be as to the matter of causation, the lesion is there, and modifies the conditions of the cardio-pulmonary circulation in the manner most favorable for the production of hemorrhage. In fact, by this alteration of the aortic orifice, the left ventricle and auricle are kept in an abnormal state of repletion and distention. As a consequence, the pressure is constantly increased in the veins which empty into the left auricle, *i. e.*, the pulmonary veins. Let

there then be an exertion which suddenly raises this already excessive tension, and ruptures will take place in the finer radicles of that portion of the vascular system involved, that is to say, in the alveolo-bronchial plexus of the pulmonary veins.

Such is the cause, and such is the mechanism of the hemorrhage, with which this patient was suddenly seized on the occasion of his violent run. The focus of inflammation in the left lung indicates the spot at which the blood was poured out; it was the effusion which caused this inflammation in the tissue of the lung, and the symptomatic fever.

During the six days which have elapsed since the admission of the patient, we have observed favorable modifications as far as the hemorrhage and fever are concerned, but unfavorable changes in respect to the lesion of the left lung.

The hæmoptysis persisted with the same bright red appearance during the day of the 16th and the night of the 16th; there was none on the seventeenth day, but it returned in the night of the 17th, though in smaller amount, and has twice since been repeated in the night time, but it has ceased since yesterday morning. The fever fell to 100°, as you see by the tracing, but yesterday afternoon it went up to 102.°2, so that we cannot yet prognosticate anything as to its further evolution. His general state is very satisfactory, considering the symptoms from which he has suffered. There are no bacilli in the expectoration, which for twenty-four hours has been composed of dark bloody sputa, mixed with viscid mucus.

During this same interval the focus in the left lung has steadily grown larger; and this very morning I called your attention to the modifications which have supervened. Last Thursday, forty-eight hours ago, there was in an area as large as the palm of the hand only a slight dulness and fine râles; to-day the lesion has increased below and above, even to the apex of the lung, and the condensation of the tissue is notably augmented; the dulness is complete, and in all that zone the râles of variable volume are mingled with blowing breathing and bronchophony.

The elevation of temperature last evening was probably the result of this aggravation of the local trouble; what is quite certain is that we find in that one spot, ten days after the occurrence of the accident which brought him before us, a focus of pneumonia created by the hemorrhage, and that this focus was already appreciable on the fourth day, and that since then we have followed day by day its development and the modifications which it has undergone. This first phase of the case which must be clearly understood in order that you may well comprehend what comes after, is then of exceptional precision. And now the principal question presents itself: What is to be the future of this patient? We cannot tell to-day, for his destiny depends on the uncertain and variable evolution of the pneumonic *foyer*, the result of the hemorrhage.

A simple resolution is possible; this favorable termination, which implies before all a stationary condition of the actual lesion, may take place after an interval of from six weeks to three months. The pneumonic focus may persist without any extension and without change in its character, and may result in the destruction of the central portions of the lung by the continuity of the inflammation, and by elimination of the fibrinous nodules resulting from the stagnation of the blood. The observations of Thomson have called our attention to this favorable course which I have never observed. It is not, by any means, as fortunate a termination as the preceding, but it has not the irremediable gravity of that kind which I am about to indicate to you.

The lesion caused by the hemorrhage is never repaired, or is repaired only very incompletely; a residuum persists, and the condition of the patient is precisely what I described a year ago when speaking of the imperfect resolution of pneumonia. In the neighborhood of this persistent lesion the vitality of the tissue is lessened; it is in a state of *sub-nutrition*, and becomes therefore a favorable culture soil for the fixation and multiplication of the bacillus tuberculosis. Let but the microbe obtain a lodgement in these conditions, it will certainly find a suitable habitat, and the pneumonic *foyer* will be transformed into a *foyer* of bacilli.

You see here, gentlemen, a good example of phthisis from hemorrhage, and I have told you how to grasp and interpret it. This patient, then, furnishes a new instance of that form of phthisis which has been denied by some, though wrongly; and it is the more convincing from the fact that the initial hemorrhage did not take its origin in the respiratory apparatus.

March 26, 1887.—The result has confirmed my previsions. The patient succumbed March 19 to pulmonary tuberculosis, three months and one week after the first attack of hemorrhage. During that time we noted the extensive ulceration going on at the primitive focus of the left lung, the pro-

gressive infiltration of the whole of this same lung, and till the end we could testify to the perfect integrity of the right lung.

The hemorrhage was not repeated, the expectoration gradually became purulent, and from the last of January we found bacilli in abundance, although they were vainly sought during the weeks which followed the admission of the patient into the hospital.

During December, January, and the greater part of February, the fever was very irregular, often intermittent, sometimes *nil*, but from the 25th of February it became high and continuous, and remained to the end between 100° and 102°.2 F.

The autopsy has been singularly confirmatory of our diagnosis; you may convince yourselves of this by examining the specimens which I here show you.

The left lung is riddled with little cavities in all its upper half, and the largest cavity, which exceeds the size of a large chestnut, corresponds exactly with the crepitant focus noticed on the entrance of the patient, the focus which remained for a long time the only lesion. In the spaces between these cavities, and in its whole lower half, the lung is the seat of a solid tuberculous infiltration.

The right lung is absolutely healthy; it contains not a single tubercle, and presents only a slight œdema.

The aortic valves are rigid, indurated and thickened by the old atheromatous deposits which extend throughout the whole thoracic aorta.

Remember, gentlemen, the lesson which this case teaches. It shows once more the reality of phthisis *ab hæmoptoë*, and fully justifies the doctrine which I have so long taught, of pulmonary hypotrophy (subnutrition) as a cause of tuberculosis.

—According to M. Luc and some others, there exists a variety of tracheitis, associated with nasal ozæna, but which, once established, evolves independently of the latter. The tracheitis is characterized by fœtid secretions in which the microscope reveals the presence of micro-organisms similar to those found in the crusts from the nose in cases of ozæna. The scabs on the walls of the trachea do not proceed from the nose, but are autochthonous. The clinical characters of tracheal ozæna consist in expectoration, especially in the morning, of greenish sputa, thick, viscid, and exhaling the peculiar odor of ozæna, and the persistence of the fœtor of breath after thorough cleansing of the nasal fossæ. Laryngoscopically, the crusts may be seen on the walls of the trachea.—*Lancet*, March 24, 1888.

Communications.

Ovariotomy.

BY R. STANSBURY SUTTON, M.D.,
PITTSBURGH, PA.

It has been stated that to offer anything further upon this subject one should offer an apology for so doing. It is not so, else all who are interested need nothing more. The doing perfectly, every time, of any one operation is rarely the gift of a surgeon. We all operate much as we feel—well to-day, indifferently to-morrow. Surrounded to-day with favorable conditions, to-morrow with unfavorable conditions. To-day with skilled assistants; to-morrow with assistants who have no dexterity, or experience upon which to attempt any. To-day with a case sent early for operation; to-morrow with a case which has been the subject of the most brutal ignorance, trocar-marked from ensiform to pubes, her physical powers exhausted, and her sorrowful poverty somewhat to be accounted for by faith in drugs. So long as "absorbtion" is advocated as a remedy, so long as the brutality with the trocar continues, so long as women are urged to "wait until you must be operated on;" so long as all are not familiar with the operation itself, and all of its favorable and unfavorable surroundings, its elements of success and failure—so long we should continue to write and abjure apologies for so doing.

The obstetrician teaches first the mechanism of normal labor, subsequently the mechanism of difficult labor. It is the natural order. The young obstetrician is a success; the majority of labors are natural labors. The management of these gives him confidence, and when he advances to the difficult cases he is prepared to succeed. No one says to him let that woman alone until the angel of death is at her door and then aid her, but all say go! examine, give proper attention, aid her until delivered. When such action shall be the rule with women suffering with intra-abdominal cysts few will die, not more than die in childbed. Normal labor and early ovariotomy may be equally successful. Often men report, as I have done, their failures and success, some their success only. Few report their cases with the sole object of doing good to humanity; I do not claim that I do, if I did I would not be believed, perhaps properly so. But in giving the following typical case of a simple ovariotomy, I claim these objects, viz., *to teach those who desire to be taught the importance of early ovariotomy*,

its simplicity and its glorious triumphs, and to warn those who oppose the operation, and who maltreat these defenceless patients through their deplorable ignorance or woful stupidity.

Case 64.—April 30, 1888, Miss W., Pennsylvania, a stranger to me, aged 32, unmarried. On examination presents a multilocular ovarian cyst. Nothing excepting her size obstructs her daily duties. She is a feeble woman by nature. An examination of three minutes' duration without any instrument whatever established the diagnosis. Her period is due in two days, May 2.

May 2d to 6th menstruated.

May 8th, she entered my private hospital, 8 P.M., and had a full hot-bath.

May 9th, A.M., a dose of purgative (compound liquorice powder); light diet throughout the day.

May 10th, A.M., breakfast of soup, bread and coffee; no dinner. Etherized in bed and conveyed to the adjoining room for operation at 2 P.M.

Present, Drs. Williamson, Huselton, Davis, Lindley, Blackley and Dodds.

A four-inch incision, without the aid of grooved director, was completed in ten seconds. A large trocar rapidly reduced the cysts, which were delivered long before they were empty. The pedicle which was short and broad was tied, cut off and burnt, and two minutes and thirty seconds more time had gone.

The second ovary, which was diseased, was removed and its stump seared with the Paquelin; by this time not quite five minutes had gone. Two pitchers of warm water were poured into the cavity of the abdomen and sponged out, the sutures were introduced and tied and the wound closed, all in eighteen minutes; weight of cysts and contents fifteen pounds. On the following day pulse 96, temperature 99½° F. On the second day pulse 90, temperature 100° F. On the third day pulse 84, temperature 98½° F. On the fifth day stitches all removed, wound entirely healed, appetite and sleep normal, and the patient left to the nurses.

Such is the history of operations in simple cases, cases operated upon early. If this simple lesson will help the cause its aim will have been accomplished.

—The nineteenth annual session of the Medical Society of Virginia will be held in Norfolk, Tuesday, October 23, 1888. Upon the Society devolves the duty of appointing the thirty-two members of the Medical Examining Board.

HYPODERMIC USE OF NITROGLYCERINE IN HEART FAILURE.

BY M. HOWARD FUSSELL, M.D.,
PHILADELPHIA.

The results of the hypodermic use of two drops of a one per cent. solution of nitroglycerine, in the following cases of heart failure, were so satisfactory that it seems a matter of importance to the writer to place them on record.

Case 1.—Mrs. G., aged 63, subject to dyspnœa, palpitation and recurring œdema for several years, had a slight cerebral hemorrhage two years ago. Examination at that time showed disease of the mitral valve. Under treatment with digitalis and strophanthus, the case progressed favorably until January, 1888. Suddenly on the night of January 2, the patient, after having passed an unusually good day on the first, was seized with urgent dyspnœa, so that she was unable to lie down, and she became so sick that I was summoned about 3 o'clock in the morning. I found the patient unconscious, both her lungs full of bubbling râles, her pulse ninety and weak, but remarkably regular considering the patient's general condition. Her breathing was stertorous, and could be heard in the next room.

The patient having previously had cerebral hemorrhage, I at first thought this attack was a recurrence of the same trouble; but the fact that there was no recognizable paralysis caused me to doubt this diagnosis. The patient's condition was so bad, however, that I told the family she was the subject of heart failure, and in all human probability would die in a short time.

At this juncture I remembered a remark made to me by Dr. John H. Musser, of West Philadelphia, to the effect that he was certain he had in such cases saved life, at least temporarily, by hypodermic injections of amyl nitrite.

The patient had been taking nitro-glycerine before the attack, so I procured the bottle, gave a hypodermic injection of two drops, and retired from the room to await the death of the patient. In just twenty minutes from the time of the injection the attendants called out that our patient was dying. I went into the room, and, instead of finding her dead, saw that she had raised herself in the chair in which she was propped, and was evidently conscious. I spoke to her and received an intelligent answer. Her pulse had become still more regular than it had been before, and her breathing less

labored. I immediately repeated the injection of nitroglycerine, and in the course of an hour had the satisfaction of seeing my patient's condition so much improved that she was able to talk and could lie down without trouble, while the râles had disappeared from all parts of her chest, except the extreme bases of the lungs. In a few days the condition of the woman was quite as good as it was before the attack, and she was able to go about the house comfortably.

Case 2, was one of typhoid fever. The patient, a man 45 years old, had had a remarkably light attack of fever, his temperature never rising above 102°, and by the end of the second week it had reached the normal point.

On the sixteenth day of the disease the patient awoke in the morning saying he felt better than he had felt on any previous day. Notwithstanding the repeated warnings he had received not to make any undue exertion, he arose suddenly from his bed, reached under it for the commode, and immediately fell back in a faint. I was sent for, and on my coming found the patient in a deplorable condition. His pulse exceedingly irregular and weak, and so rapid that it could not be accurately counted; his face cyanosed; his hands and feet cold; his lungs full of râles. I immediately administered two drops of nitroglycerine hypodermically, and applied heat externally. In a few minutes I had the satisfaction of seeing my patient's condition begin to improve. His pulse became more regular, though still exceedingly rapid, and his breathing less labored. Stimulants were then administered, and he gradually improved for two days, when death took place from another attack of heart failure, following a persistent straining at stool.

Case 3.—A man, 59 years old, an habitual drinker, and the subject of mitral disease of the heart. After retiring on the evening of May 1, he was suddenly attacked with urgent dyspnœa. He arose, was propped in a chair, and tried vainly to obtain relief from his oppression. I saw him one hour after the beginning of his attack, and found his pulse irregular, rapid and weak. His breathing was rapid, his face cyanosed, and his lungs filled with bubbling râles. He was conscious, but unable to speak connectedly. Remembering my former success with nitroglycerine, I immediately injected two drops hypodermically. This was followed in a few minutes by marked relief. In half an hour I injected one drop. At the end of three-quarters of an hour the patient's pulse was regular; he could talk easily; his breathing was almost normal. I then ordered whiskey and digitalis to be given during the night, and in the morning found him exhausted, but almost in his normal condition.

In all of the above cases death seemed imminent. In the first case the woman would certainly have died very soon had she not received prompt relief. The treatment by the hypodermic use of nitroglycerine acted so promptly that the bystanders were very much impressed, and the physician was almost as much astonished as they were.

I have treated similar cases with stimulant hypodermics of whiskey and digitalis, but sometimes death was not averted, and when it was the relief was long delayed.

One who has seen cases of heart failure treated in the usual way can have no conception of the brilliant results which may be obtained by the hypodermic use of nitroglycerine. The treatment has the great advantage that it is harmless in any event; and I believe it should always be tried, though, of course, not to the exclusion of other well-known methods of relief.

SPINA BIFIDA.

BY SAMUEL WOLFE, M.D.,
SKIPPACK, PA.

On the 18th of March, 1888, Mrs. B., aged 27, was delivered of her second child. The size, weight and general appearances of the child presented nothing peculiar. Over the spine, in the dorsal region, extending downwards, from a little above the middle of that region, for three inches, with a breadth of two inches in its widest part, was what appeared to the eye a raw patch, looking very much like a gaping incision through the skin, in a muscular region, which had become somewhat glazed by having been left undressed, after having been thoroughly cleansed. The ends of the patch tapered from a sharp point above, to a more obtuse termination below. Several longitudinal streaks of yellowish-white traversed it from above downwards. At several points there was the very slightest oozing of blood, and a high degree of injection of very small vessels. Along the lateral edges of the patch could be felt a row of bony, obtuse points.

The frontal bone was incomplete to the extent of two fingers'-breadths, from the anterior fontanelle to a level with the frontal protuberances. The parietal bones did not meet within one finger's-breadth. Over the lines of the other sutures there was less, but

still undue separation. There was very slight bulging of the skin in the region of the frontal deficiency, but the size of the head was normal, with no evidence of accumulation of fluid within the cranial, or rather meningeal cavity, unless the slight bulging, already noted, might be thus regarded. The limbs were well developed and well shaped. The spinal defect was dressed with ung. zinci oxidi. Within thirty-two hours there were evidences of healing from the edges of the raw surface, and the dressing was continued. About the fifth day a yellowish membrane had formed over the surface, and there was active secretion of pus. The surface was cauterized with argent nit., which apparently gave no pain whatever. This line of treatment was continued throughout, and the healing action under it made progress. On the third day the slight bulging in the frontal region had receded. During the fourth week the head began to enlarge, with all the characteristics of hydrocephalus, slight convulsive twitchings occurred, the strength began to fail, the flesh to waste, and just before having completed the fifth week of life, it died of exhaustion. The spinal affection had not materially changed. During the first three weeks the heart had been normal in its action, the bowels and kidneys acted regularly, the child nursed well, and in every respect the condition was thriving. During the last two weeks the lower limbs became contorted by tonic contractions, twisting the feet somewhat inward and upward. With the aid of Mr. J: N. Hunsberger, my student, I dissected the affected spinal region, finding the coverings, though with difficulty separable and distinguishable, to represent skin without epidermis, dura mater, and arachnoid. About a half fluid drachm of pus escaped when the inner covering was incised, and with it a white cord about one inch in length, and resembling a nerve of medium size in thickness, and of a consistence much softer than a normal nerve, flattening under pressure between finger and thumb. This was all that was found to indicate the presence of the cord, and it escaped with the pus in such a manner as to seem to have had no attachment. Of bone, there was absolutely nothing but the bodies of the vertebræ, which were held together by a tissue resembling in position and strength the posterior common ligament. There was some arching backward. The bones involved were the five lower dorsal and two upper lumbar vertebræ. Downwards, no trace of a spinal canal could be found; upwards, its calibre was very small and apparently tortuous, but as the dissection was not carried beyond, I can give no more details besides stating that the external appearances in the rest of the course of the spinal column were normal.

As to the family history, the mother had one year and two months before given birth to her first child, which was similarly deformed as to the spine, except that the affection was then located lower down, entirely in the lumbar region. There was also talipes in that case. No defect in skull, but general condition feeble. The child died on the third day after several convulsive spasms. No post-mortem was made. The mother is a healthy woman. The father also in good health. One of his brothers died in infancy; he does not know of what disease. A sister was temporarily insane at the age of 20, the cause apparently having been disappointment in love. She was afterward restored, married, had six children, and committed suicide by hanging at the age of 40.

The literature on the subject of spina bifida seems to be comparatively meagre, but from all I can find the above case has but seldom had its analogue amongst those reported. The position of the affection is almost constantly in the lumbar or sacral regions.

The skin is in all cases, so far as I can find any record, normal, or simply thickened, or thinned or discolored. There is always bulging, forming a tumor of the size of a walnut to that of an orange, and frequently much larger. There is always a collection of fluid (cerebro-spinal). In this case there was none. The advancing hydrocephalus did not affect the spinal disease, indicating that no direct communication between spinal and cranial cavities could have existed. The remarkably small quantity of nerve substance found, was also peculiar. The cord in many, probably most cases, presents little abnormality, except the effects of pressure or adhesions.

The theory of Lowne, that excess of cerebro-spinal fluid is the active factor in the causation of the disease, will not apply here, and I may venture the suggestion that even in the ordinary, typical cases, the excess of fluid is due to the want of resistance, from the imperfect formation of the osseous canal, rather than the latter an effect of the former.

The one practical lesson, which I draw from these two cases, is, that when the mother again becomes pregnant, I will administer during the entire period of gestation, such drugs as are calculated to stimulate the bone-forming forces, and to administer in the shape of food, cod-liver oil and lime salts, a pabulum for such forces to act on. It might even

be justifiable to put both parents on a suitable regimen, previous to the occurence of conception.

CREASOTE IN PHTHISIS.

BY FREDERICK L. LADUE, M.D.,
ALBURGH SPRINGS, VT.

While fully realizing that the termination of any one case after treatment by a method not thoroughly established is an insufficient criterion of the merits or demerits of any new departure in therapeutics, yet I am convinced that in such a formidable disease as phthisis pulmonalis the profession is not averse to having their attention drawn to a favorable report of a case treated with drugs but little used, no matter how irrational or empiric their use may be, provided only that they promise help in the stern battle with that insidious foe, tuberculosis. Probably in no other common disease has the profession evidenced so much avidity to grasp at empirical, undemonstrated and unscientific methods, as in the disease in question. This results undoubtedly from our utter helplessness when face to face with the disease in its later stages. The recent craze for rectal injection of gases is testimony for this statement.

Since the announcement of the bacillus theory of phthisis the line of investigation has materially changed, and where once the only fight was on the defensive—repairing the damage done by the silent enemy—now the base of attack is changed, and the grand charge is tending toward annihilation of the enemy itself. Medical men exhibit a strange inconsistency between their belief and their actions. While thoroughly believing and accepting the theory of Koch and learnedly talking and writing of germs and microbes, yet they make no pretense to the destroying of the germs themselves. Valuable time and valuable lives are wasted in temporizing with the old modes of treatment which, while good so far as they go, fall short of the mark set up by Koch. If we are to accept the germ theory—and microscopy says we must—then why not try antiseptics and germicides? Experience has fully demonstrated the fallacy of our old methods of treatment. One-seventh of the entire population falls a victim of this disease, showing conclusively how futile are our powers in the face of this scourge.

Doubtless it was by this or similar reasoning that Sommerbrodt, whose name may yet be placed with Koch's, resorted to the use of creasote. This well-known germicide has been demonstrated by Sternberg to be fatal to micrococci in the strength of 1 to 200. While Sommerbrodt admits that it may not be from its antiseptic or germicidal powers that it benefits, but that it may be simply from its favorable action upon digestion, still he advises that it be pushed to its utmost limit of toleration, as here is where so many fail in its use. Pushing it to this extent would be unnecessary if its beneficial action was expended only upon the process of digestion and assimilation; for experience with the drug plainly shows that it is the small doses and not the large which assist digestion, and that the large ones which he advises occasionally irritate the stomach. He says that disappointment arises only through timidity. "The more creasote that can be borne the better the effect," is his dictum. He claims to have treated 500 cases during the past nine years, and of those treated by Bouchard's formula, 27 per cent. recovered. Others were treated by the following formula, which gave the best results:

℞ Creosoti.....mx xv
Tr. gentian.....mxlv
Spir. vini rect.....f℥viss
Vini Xerici q.s. ad.....f℥iij

Of this one ounce was taken three times a day. The creasote was gradually increased to thirty grains. He obtained the best results by following treatment for from three months to a year. The most benefit was seen in the young and in the first stages of the disease, when the symptoms were not well defined. Good results were always secured when scrofulous glands were present. It generally relieved irritation and cough, and secretion and expectoration diminished, so that narcotics could be dispensed with.

Dr. J. Solis-Cohen has used creasote for many years, not as a specific but to prevent retardation of the decomposition of undigested nutriment. He has used it in chronic diarrhœa for twenty-five years. He has found that the beechwood creasote is the best to use, and rarely exceeds one-half minim at a dose. He claims to have used this with such benefit for twelve years that he rarely uses oil or hypophosphites.

Mrs. G. M., thirty-six years old, was seen first for her present trouble, December 3, 1887. I had treated her four years before for incipient phthisis, but had heard nothing from her during the intervening time. On November 1, one month before I saw her, she gave birth to a child, and since her confinement had rapidly failed until she sank into a condition of tuberculosis in the third stage.

Her condition was as follows: Temperature 103°; profuse sweating at times; violent cough and abundant expectoration of yellow mucopus; violent delirium occasionally, but never quite herself. Physical examination disclosed the fact that there were large cavities in the apex of the left lung and flatness upon percussion in other portions of the same lung. Auscultation showed the vesicular murmur absent in the apex of left lung, and the presence of blowing, gurgling respiration with bronchial breathing in other parts. The pulse was 120; there was no appetite. I immediately began the use of creasote, giving one minim three times a day, and gradually increasing drop by drop until the amount of thirteen grains was taken (January 14, 1888) at a dose. At that date the delirium had entirely disappeared, sweats greatly diminished, cough slight, and little if any expectoration. She has gained strength, flesh and appetite. She sits up four hours a day, whereas ten weeks ago she could not get out of bed. At the date of present writing, May 1, she is around the house, gaining flesh and feeling well. The lungs have improved, and the gurgling sound of air bubbling through fluid is gone. She has taken creasote constantly for four months with two interruptions of one week each. She has taken as high as eighteen grains at a dose without visible inconvenience. During this time she has had no other medication, and her diet has been principally composed of crackers and potatoes. I should state, however, that she had small quantities of whiskey part of the time.

—M. E. Beaupère, basing his opinion upon twenty-six observations made for the most part in the service of M. Levrat, at the Charity, concludes as follows:

Chloroform is indicated for the performance of tracheotomy in children attacked with croup. It acts in small doses and rapidly, without provoking in most cases the period of excitation. It does not increase asphyxia, it stops laryngeal spasm, and renders the operation more easy by making the child immovable and by the absence of congestion of the veins of the neck. Far from predisposing to syncope, it can, on the contrary, prevent it by diminishing inhibitory susceptibility of the region. Its use does not influence the subsequent evolution of the diphtheria. It enables one to dispense with several assistants. The only contra-indications to its employment are advanced asphyxia or lesions of the lungs. —*Bulletin Médical*, April 15, 1888.

Society Reports.

AMERICAN MEDICAL ASSOCIATION. —SECTION WORK.

Third Day, May 10, 1888.

SECTION ON DISEASES OF CHILDREN.

Dr. D. A. K. Steele, of Chicago, read a paper on

The Surgical Treatment of Empyema in Children.

In the consideration of its surgical treatment we must remember the surgical maxim that "wherever we have a pus collection it must be evacuated in the speediest, safest, and most thorough manner." In the majority of cases it is my belief that a purulent pleuritis is due to auto-infection of a more or less limited area of the inflamed or damaged pleura through the medium of the general circulation; the pus microbe thereby gaining entrance and commencing its destructive action upon tissues which otherwise would only be the seat of a simple pleuritis. Other methods of infection are the use of unclean aspirating needles; rupture of the bronchus; extension of a septic pneumonia; secondary infection from the primary foci in some other point of the body; tubercular infection, etc. Empyema, if left to itself, may terminate in recovery in one of three ways according to L. Emmet Holt—(1) by spontaneous absorption of the purulent effusion; (2) by evacuation through the bronchus; (3) by opening externally through the intercostal muscles; but when left to nature the mortality is appalling. Rilliet and Barthez mention 33 cases, with 4 recoveries, 21 deaths, and 8 not accounted for.

In regard to the surgical treatment, no absolute rule can be laid down for the management of all cases. We have our choice of operations from the following: For example, we may resort *first* to aspiration; *second*, aspiration and washing out of the cavity with an antiseptic solution; *third*, thoracentesis with trocar and canula; *fourth*, thoracentesis with sub-aqueous drainage; *fifth*, simple incision; *sixth*, simple incision and drainage; *seventh*, simple incision with through and through drainage, with or without antiseptic precautions; *eighth*, subperiosteal resection of rib and drainage; *ninth*, thoracoplasty (Estlander's operation); *tenth*, perflation. Each of these various methods will give good results. As a matter of fact, as practical surgeons, we may confine ourselves to the relative merits of but two of these methods—aspiration and

free incision with drainage. There is no question but that in a certain minority of cases in children, simple aspiration once or twice repeated, will effect a permanent and satisfactory cure. Aspiration has the advantage of being simple, safe, and occasionally curative; but if we find the fluid really accumulates, or septic symptoms are developed, then a free incision with drainage is imperatively demanded. Aspiration has the disadvantage of leaving a small amount of pus for reabsorption, or which may become an inspissated residuum that will result in a secondary abscess in after life. Surgically considered, it is not as perfect an operation, or as scientific a procedure, as evacuation by free incision and the introduction of a large-size drainage-tube. Of 121 cases treated by aspiration alone, 23, or 19 per cent., were cured, six died, and the rest came to some other treatment, usually incision. In regard to Ewart's method of perflation, reported last year, I have no personal experience.

In conclusion, therefore, I may summarize my observations as follows:

(1) The surgical treatment of empyema in children is eminently satisfactory and yields better results than in adults. (2) Multiple hypodermic aspirations are necessary to perfect a diagnosis, and should always be resorted to in cases of thoracic disease about which there is any element of doubt, especially in cases of pneumonia that exceed the usual period and become "old-monia." (3) Aspiration cures a small minority of cases and should always precede a more radical operation, especially in localized empyemas. (4) Free incision and drainage, with local anæsthesia, under strict antiseptic precautions, gives the most satisfactory results in the majority of cases. (5) Subperiosteal resection of the rib is sometimes necessary to afford perfect drainage. (6) Thoracoplasty is rarely required in children. (7) Other methods of treatment should be resorted to for special cases or circumstances. (8) Early incision, perfect drainage, and complete antisepsis should be the rule.

SECTION ON OPHTHALMOLOGY, OTOLOGY AND LARYNGOLOGY.

The session opened with a paper by DR. E. FLETCHER INGALS, of Chicago, on

Naso-Pharyngeal Fibromata.

He reported four cases to the section in 1884, two of which had been cured, and two of which had disappeared. He advocated the extirpation of these growths, when possible, through the natural passages by means of the galvano-cautery ecraseur or other methods employed by laryngologists in the destruction of nasal polypi, in preference to the formidable operation, including removal of the superior maxilla, which has frequently been practiced by surgeons and which is still believed by some to be the best means of eradicating such growths.

Dr. Lincoln, of New York, had shown that the operation usually adopted by surgeons was extremely hazardous, over twenty-five per cent. dying from the operation, while it was not very successful in preventing recurrence, as in only about fourteen per cent. was it certain that the tumor had not returned within a year, while by the method which he then recommended it was shown that the danger to life was very much less and that the ultimate results were much better, as in over fifty per cent. recurrence had not taken place within twelve months. Recently, one of the cases then reported, which had failed to return after the first sitting for completion of the operation, and which he had lost sight of at the time his paper was written, had returned after the lapse of five years with a renewed growth in the same locality. This was removed by means of the galvano-cautery ecraseur. The operation was done after the parts had been anæsthetized by cocaine, and was completely successful in removing all the tumor, which consisted of three lobules which had been attached by a base about half an inch in diameter at the vault of the pharynx and posterior nares of the left side. The tumor removed five years ago had the appearance of being composed entirely of fibrous tissue. Of the tumor recently removed, the smaller lobules, which measured about five-eighths of an inch in diameter, proved upon microscopical examination to be made up of fibrous tissue; the next larger lobule, which measured about three-eighths by one-half inch, appeared to be fibro-cellular in character, about one-half fibrous; and the largest, which measured about one by two inches in diameter seemed also fibro-cellular, about three-quarters fibrous.

He had also to present to the section the history of a case and the specimen (a large fibrous growth) recently removed from the nasal pharynx with the galvano-cautery ecraseur.

The patient, W. K., aged sixteen, for two years had been troubled with difficulty in breathing through the nose, and frequent epistaxis. For about two months before consultation he had suffered from frequent alarming hemorrhages, during one of which his attending physician had been called in for the first

time. The doctor checked the hemorrhage, but the patient was much exsanguinated and in no condition for an immediate operation; therefore he was placed upon tonics and nutritious food and given time to recuperate. Dr. Ingals found the patient well nourished and with no appearance of anæmia. His voice was of that peculiar character known as nasal; the sense of smell was nearly lost, and he complained of pain in the side and back of the head. The left cheek over the lower maxilla was quite prominent and apparently swollen, but there was no induration excepting just opposite the posterior molar of the upper jaw, where a conical tumor could be felt deep in the soft tissue. This tumor appeared to be about five-eighths of an inch in diameter at farthest point where it could be felt, which was about the same distance back of its apex, and it was evidently attached far back in the tissues out of reach. Upon examining the nares anteriorly, the posterior third of the left cavity was found filled with a firm growth of a light pink color, which bled very easily on being touched with a probe. Examining the mouth, the soft palate was seen to be crowded downward, and rhinoscopic examination discovered the naso-pharyngeal cavity to be filled with a firm tumor of a light red color and smooth surface. The slow progress of this case, the frequent attacks of epistaxis, and the appearance of the growth itself, convinced Dr. Ingals that it was a fibroma. He recommended removal by the galvano-cautery ecraseur and left the patient to decide whether it should be done under the influence of cocaine or ether. On the afternoon of the same day he operated. A ten per centum solution of cocaine was first applied to the nasal pharynx and left naris, by means of an atomizer and syringe, about once in two minutes for fifteen minutes until the parts were insensible. He then passed through the left naris two catheters which were brought out of the mouth, and though these were passed the two ends of a number eight platinum wire, and these were drawn out of the nostril with the catheters; the loop was carried up behind the tumor by the fingers; the ends of the wire were then passed through a tubular electrode and made fast to a rachet on the handle, and the battery was connected. He now tightened the loop by turning the rachet and then heated the wire for two or three seconds by closing the circuit; then allowed the patient to rest a few seconds, and then repeated the procedure, thus alternately heating the wire as long as the patient could easiiy bear it and then allowing it to cool, and, tightening the rachet, he soon burnt off the growth at its base, which was more than an inch in diameter. The tumor was removed through the mouth and proved to be a hard fibrous mass, measuring one and three-eighths by two inches in diameter, and one inch in thickness. During the past three years he had operated on two other cases of naso-pharyngeal tumors which appeared at first to be simple fibromata. The first case, A. B., aged thirteen, was brought to him from Dakota, and during the course of a year and a half underwent three distinct operations, in each of which the tumor was removed as thoroughly as possible, but a small portion of it, which was doubtless left in the tissues about the pterygoid process, could not be extirpated. The late Professor Moses Gunn at one time removed a tumor, which was about an inch in diameter from this patient's cheek. During the last six months of the treatment the tumor grew so slowly that he hoped for its complete destruction.

The second of these cases, E. J., aged about 13, was brought to him from Nebraska, about two and a half years ago, with a fibrous tumor which filled the left naris and naso-pharyngeal cavity. In this case the tumor was removed partly by the galvano-cautery and the steel wire ecraseur, and partly by cutting forceps. There was profuse bleeding whenever the cutting forceps was used, but it was readily checked by tamponing the nasal and naso-pharyngeal cavities with a strip of gauze, saturated with a mixture of tannic and gallic acids, which had been rubbed up with just enough water to make it the consistence of syrup. The record of the case has been lost, but three or four operations were done at intervals of from three to five months, each time the growth being removed as completely as possible, part of it having penetrated the surrounding bony structure. The last operation was done about a year ago, and he has not since heard directly from the patient, but from another patient who knew of the case, he has recently learned that the boy is living, and, that so far as the friends can tell, the growth has not returned.

Dr. Ingals believes that all of such cases which afford any hope of cure should be operated upon through the natural passages. When the growth has been removed, if any parts remain which are inaccessible to the ecraseur, cautery, knife, or cutting forceps, they should be treated by electrolysis, and thus even if we fail to eradicate the growth at once we may hope to prolong the case to the period of adolescence, when nature seems to set a limit, at least, in many cases to the further

development of these growths, and then a cure will be effected.

SECTION ON MEDICAL JURISPRUDENCE.

DR. DANIEL R. BROWER, of Chicago, spoke of

The Medico-Legal Relations of Hysteria.

The close relation hysteria bears to insanity makes the question of the legal responsibility of its victims often exceedingly doubtful. Under the overwhelming impulse of a perverted nutrition these patients may commit murder, incest, or other crimes. Under the domination of disordered imagination, they may make accusations of pretended assaults upon their persons, and a variety of other crimes; or they may justly claim recompense for the development of this abnormal condition of the nervous system as a consequence of the shock of railroad and other accidents.

Hysteria is a *psycosis*, the primary derangement being in the higher cerebral centers. The lower centers of the brain, the spinal cord, the sympathetic nervous system, are only secondarily affected. It consists essentially of a depressed condition of the intellectual and volitional areas of mental action, and an excitation of the emotional and perceptional areas. This condition of mind produces a defective will power; an imperfect self-control; an insatiable craving for sympathy; an exceedingly irritable and irascible disposition, and with this is very often associated sometimes as an inheritance, sometimes as an outgrowth of this unbridled emotional condition, a defective moral tone, and sometimes an unnatural and ungovernable activity of the sexual system.

The morbid excitement of the sexual organs of these hysterical patients sometimes places them in medico-legal relations. There are many examples in the annals of medical jurisprudence of women who prostitute themselves without reference to the social condition of the man. Charcot furnishes the case of a young Austrian noble-woman of great beauty, who offered herself to every man, even to the lowest street character. She gave birth to a child which she subsequently decapitated without appreciating at all the nature of her criminal act. To this class of cases belong, at least, some of the cases of pretended assaults in physicians and dentists' offices.

A patient who was under my treatment for various manifestations of hysteria was sent by me to a certain distinguished specialist in gynecology in Chicago for local treatment. She made several visits to his office and a few days after the last visit sent for me. She told me that the specialist had committed an assault upon her while giving her treatment, and that, as a consequence, she had missed her menstrual period and was now pregnant. She indulged in the most violent language possible, and her husband and mother were inclined to believe her story; and had it not been for the reputation of my distinguished friend, I might have also given some heed to her story. After a few days, however, her menstrual period recurred and thus destroyed the principal foundation upon which she built her theory of assault. Had her menstrual period not returned, or had the specialist been a man of less reputation, a scandal, at least, might have been perpetrated. In my opinion gynecologists, who make examinations and treat such patients in private, are constantly in danger of such accusations.

To this same order belongs certainly some of the cases of beastly and brutal crimes committed by men, such as violent assaults upon children, and inversion of the sexual function. The case of Lord Clinton, in London, is an illustration; and in the annals of our own (Chicago) courts and those of other cities, arrests are not infrequently made for violence of public decency. Men dressed, for example, in women's clothes soliciting other men for purposes too vile to mention, are, at least, associated very often with this hysterical condition of the nervous system.

Another important legal relation of hysteria is that which grows out of railroad and other injuries. It is a well-recognized fact that nervous shock, from whatever cause it may originate, will develop the hysterical condition in those who have any tendency thereto, and strong and healthy men and women have been time and again reduced by such causes to a state in which all control of the emotions and of the will power is well nigh gone; "who cannot sleep (see Page on Injuries of the Spine and Spinal Cord, p. 172), because he has before his mind the ever-present sense of the accident; who stirs at the least noise; who lies in bed almost afraid to move; whose heart palpitates whenever he is spoken to, and who cannot hear or say a word about his present condition and future prospects without bursting into tears." We know very well there are some who regard this set of symptoms as a mere assumption, but we have had sufficient experience with similiar cases, without any legal relations whatever, in which this hysterical condition has been developed, and in which the life

has been made miserable; the usefulness of the patient diminished, if not entirely overcome—sufficient experience to know that there are some cases in which shock to the nervous system does develop, without question, this condition, and make such patients entitled to as much compensation as if they had broken an arm or fractured a skull. Indeed, the award of damages in such cases should be vastly more liberal, because the usefulness of their lives in the future has been vastly more curtailed than could possibly result from any such injury as we have described. And these symptoms of nervous disturbance in such cases are doubtless exaggerated by the long and tedious process of litigation by which the settlement is reached; and it is not surprising that when the relief comes from the adjustment of the suit and the awarding of the damages, that the satisfaction which arises from this fact, and the ease and comfort of mind which follows, bring about a disappearance of all the symptoms complained of.

SECTION ON DERMATOLOGY AND SYPHILOGRAPHY.

Dr. H. J. Reynolds, of Chicago, reported the following

Case of Nævus.

J. E. H., 10 years old, native of Minnesota; American parents; father healthy, mother died of inflammation a few days after the birth of the child, who is the subject of this report. The child has had ever since birth a thick, fleshy, prominent purplish colored growth, extending from a little below the left knee up to above the crest of the ileum. The growth encircles the lower part of the entire leg, except a narrow strip on the inside. Viewed anteriorly it recedes, extending from below up slightly to the left, so that the inner margin of the upper part reaches above the anterior superior spinous process of the ileum; posteriorly above the buttocks it extends slightly beyond the median line to the right. When first seen, some three months ago, the growth was traversed over almost its entire surface by numerous deep furrows. He has always been troubled with a very profuse serous sort of discharge of a very offensive odor, so much so in fact, that he was deemed unfit to be in school with other children. Owing to the maceration and irritation caused by the discharge or moisture, the growth was in places attended with more or less irritability or soreness. Portions of the surface of the growth are covered by a hard, scaly sort of substance, resembling somewhat an aggravated ichthyosis; long delicate hairs were distributed more or less scantily throughout the entire affected region. Another interesting feature in this case is the fact that the affected leg is about two inches longer than the other one; otherwise the child has always been healthy.

He had been treated more or less by various physicians, but never received much benefit. I ordered the part carefully washed once a day with soap and warm water, and impalpable boracic acid applied three times a day. I have not seen the patient since; but the following extract received in a letter from his father a short time ago explains itself. He says: "In regard to my son, whom I brought before you on February 8, I can say that your treatment is the best remedy I have heen able to find yet. The offensive odor and discharge have almost stopped, and the thickening is growing thinner in places, and the limb is in better condition than it had been since he was born, or since I have been paying close attention to it."

Favus of the Forearm.

The following case is deemed interesting chiefly on account of its very unusual location:

Occurring upon the scalp, tinea favosa is a somewhat rare disease, and extending from the scalp to the non-hairy skin of the same individual is a still more rare occurrence, but to develop exclusively on the non-hairy skin is a circumstance not very often met with.

M. L., 7 years old, of Jewish parents, and otherwise healthy, presented herself for treatment April 7. Examination revealed a roundish patch of eruption about three-quarters of an inch in diameter on the flexor surface of the forearm about the region of the junction of the middle and lower thirds. Exactly in the center of the patch was a bright yellow, sulphur-colored, umbilicated crust one quarter of an inch in diameter, with a crack across its centre, showing its brittle character. By careful examination three or four beautifully defined smaller cups about the size of the head of a pin could be observed here and there over the patch, otherwise the remainder of the patch was to all appearances identically that of ordinary ringworm, with a reddish, slightly elevated abrupt margin, with a center tending to become paler, and covered slightly with fine scales. Examination with the microscope showed the crust to be composed entirely of favus spores; scales from the reddish margin contained principally mycelia with a few smaller spores, which, as far as I was capable of judging, were identical with those found in ringworm.

OBSTETRICAL SOCIETY OF PHILADELPHIA.

Stated Meeting, Thursday, May 3, 1888.

THOMAS M. DRYSDALE, M.D., in the chair.

DR. JOSEPH PRICE reported a case of

Typhoid Fever Following Ovariotomy.

Mrs. E. N., 37 years old, one child sixteen years ago; one miscarriage fourteen years ago. She complained since her miscarriage of great pelvic pain, etc. She was operated on at the Gynecean Hospital, February 11, 1888, for the removal of the right uterine appendages. The tube and ovary were firmly adherent to and under the fundus uteri. The ovary was enlarged and cystic. The removal was not difficult and the operation was completed in twenty minutes. Two years previously the left appendages were removed for a small inflamed and adherent ovarian cyst, the right side at that time appearing perfectly healthy. The recovery from this first operation was speedy, and for a year the patient seemed in perfect health. Then the symptoms of pelvic trouble returned and were referred to the right side. From the second operation, the patient reacted perfectly, and for nine days her temperature constantly remained above normal, varying from 98°.6 to 100°.1; the intermissions never amounting to one degree. During this time she also complained of a good deal of headache, weakness and mental depression. The evening of the ninth day her temperature ran up to 102°, and she had a slight rigor. From that time she presented a typical case of typhoid fever, including the characteristic temperature record, stools and eruption. The nervous symptoms were not especially marked. The temperature varied from 99°.8 to 104°.8 for four weeks. The patient made a good recovery, and is now in better health than before the operation.

Three points of interest in this case are: 1. That the patient was probably in the early stage of typhoid fever when she entered the hospital, there having been no case of typhoid in or near the hospital at the time. 2. The operation did not seem to influence the course of the fever, nor the fever the result of the operation. 3. The temperature combined with the early constipation and meteorism were naturally attributed to the operation and treated accordingly, until the diagnosis of typhoid fever was made, after which the usual expectant treatment for that disease was pursued.

DR. J. M. BALDY reported a case of

Hysterectomy, followed in four Months by Ovariotomy and again in six Weeks by Abdominal Section for Purulent Peritonitis.

Mrs. P., 40 years old, colored, came under my care on the seventh day of last November. She had for years been suffering more or less discomfort from an enlarged abdomen. However, until within the year past she had managed to get along very comfortably. About twelve months previous to the date of my first visit, while lifting a wash-tub something "slipped back into her belly," and at the same time the abdomen became somewhat smaller. This was in all probability caused by the large fibroid uterus, which had been resting on the pubes, being suddenly dislodged. She now began to suffer acutely from pressure symptoms. The bladder and rectum prolapsed, and were for the most of the time between her thighs. She had difficult and scanty micturition, constipation was constant. Finally, the urine became loaded with pus; her abdomen became enormously distended with ascites, and she suffered constant pain, besides losing large quantities of blood. At the time of my taking charge of the case she could be out of bed only about two hours a day, on account of the great swelling of her legs and feet. She had been attended by a number of different physicians, and had been repeatedly tapped, the last tapping having been done on the Saturday previous to my seeing her. After each of these operations she was confined to bed for several days with an acute pain in the lower part of the abdomen, and she was now suffering from one of these attacks of peritonitis—so much so that I could only with difficulty manipulate her abdomen.

The diagnosis was extremely simple, and she readily consented to an operation, with the full understanding that the chances of recovery were strongly against her. On the following Saturday, just one week from her last tapping, I opened her abdomen, and removed a fibroid uterus, weighing five or six pounds. At the time of the operation her belly was so distended with fluid that her breathing was badly interferred with: over three gallons of fluid were removed. The operation was performed by the extra-peritoneal method. I was able to place the *serre-nœud* below, and including, as I then thought, both ovaries, and thus obviated the separate removal of these organs; this, however, finally proved to be a fatal mistake. In cutting away the tumor it be-

came necessary to leave part of the right ovary on the stump, in order that the button might be large enough to prevent the *serre-nœud* from slipping. The peritoneum was the thickest I have ever seen, being fully half as thick as one's finger. The patient recovered promptly from the anæsthetic, and much to my surprise went on slowly and without complication to recovery. For the first ten days I removed daily from the drainage-tube over a quart of straw-colored, syrupy fluid, and I was at one time afraid that the peritoneum would never stop secreting it. On the eighth day the stitches, fourteen in number, were removed and union found to be perfect, with no stitch-hole abscesses. On the eleventh day the discharge from the drainage-tube stopped abruptly, after a dose of salines, and never again reappeared. The tube was removed four days later. On the tenth day, while tightening up the *serre-nœud*, it broke and I was never able to tighten it afterwards. In consequence of this accident the stump was slow in coming away, and finally, after waiting a full month, and slight septic symptoms having set in, I removed the pus and cut away the decaying tissue as far as I could, and allowed the rest to retract. Within a few more days I had succeeded in getting away in small pieces the little tissue which was left.

At the end of six weeks she was out of bed and again at her work, in better health than she had enjoyed for years. The urine gradually cleared up and became normal. She had no more trouble from her prolapsed bladder and rectum; they disappeared entirely within the vagina. The depression left by the retracted stump never entirely closed, but continued to discharge from a pin-hole point, about one drop of pus daily.

Within a few weeks a ventral hernia began to show itself at the site of the drainage-tube, and gradually extended downward towards the pedicle, until finally it became as large as a big orange. This became more and more troublesome, and she complained of a dull pain at the lower part of the hernia. She being a poor woman, forced to work, and not capable of or having time to take the best care of herself, I advised her to go to bed again and have the hernia closed.

This she did on the 17th of last month. I opened the peritoneal cavity at the upper border of the hernia and slit up the tissues to the full extent of the rupture. Quite a large amount, probably a pint, of clear, straw-colored fluid gushed out. Passing my finger into the pelvis to investigate the cause of this, I was surprised to find it filled up with a cyst, having for its attachment the old uterine pedicle, which was itself thin and elongated. The pedicle of this new growth was very short and broad. After securing it with a double ligature, it was removed, and found to be a multilocular ovarian cyst about the size of a base ball. The omentum had been slightly wounded on entering the cavity, and as it bled freely a ligature was thrown around it, and a small piece removed. Everything being now cleaned up, a large flat sponge was placed over the intestines, and I proceeded to close the incision. The muscles and fascias were dissected out on both sides and united with a continuous silk suture. The wound was then closed by seven sutures introduced through the entire thickness of the abdominal wall. There was no drainage used, which was extremely unfortunate, for a drainage-tube would have saved her life. Recovery from the anæsthetic was prompt, and she seemed unusually comfortable. On the second day she complained of pain in the left chest, which for the next few days increased. This pain was apparently pleuritis, although I could discover no physical signs. She had a slight hacking cough, and about the fourth day began to spit up quite a good deal of dark colored sputa. For the first week she was extremely restless, and said she did not feel nearly as good as after the first operation. The temperature remained slightly over 100°, and the pulse about 90. On the seventh day the stitches were removed, and a drop of pus followed each of two of them; there was never any discharge from these points afterwards. This pus apparently explained her discomfort, lack of appetite, etc., but instead of improving, she grew slightly worse. From this time until the second of this month her temperature and pulse varied—on two occasions I found the temperature as high as 102°.5, but was never able afterwards to find it more than 101°.5. She complained, however, that her hottest time was towards morning, and that she sweated freely and could not sleep. Her tongue was of a nasty red color, irregularly covered with a thick white coat and pitted. By repeated examinations I could detect nothing wrong, and yet her whole condition seemed to me to be extremely suggestive of sepsis. On the seventh of the month I asked a friend to see the case with me, and advise as to the advisability of reopening her abdomen. Our decision was to wait and observe, and the old adage, "that he who

hesitates is lost," was once more exemplified. From now on I was led hither and thither by the symptoms; sometimes she was apparently much better, pulse and temperature would improve, and at one time the tongue was almost cleared, and the mouth was not so sore. About this time I noticed a distension of the abdomen, more on the left side, with a region of dulness irregularly extending from the spleen to the pubes. By change of position there was no change in the line of dulness. This led me to think that there had been an acute attack of peritonitis, with effusion, and that soon all would be well.

On the 8th of April about an ounce of pus was discharged from the site of the old pedicle, and after putting in a small rubber drainage-tube, the cavity was kept well washed out. With this cue to the probable trouble, I again lost my opportunity of operating. The symptoms all improved so much and she progressed so well for a few days that I was further seduced into the miserable policy of waiting. The pulse became 100 and the temperature 100°.5, and then things came to a standstill. I now went out of town for three days, determined to operate on my return if there was no more improvement. On my return, I found that there had been another discharge of pus, and that she was very much better. This led me into still more waiting, but without any further improvement.

Looking back over the past month, I could see a decided and alarming loss, which had been pretty constant in spite of the repeated changes for the better which had taken place in that time. On the 18th of April, about one month from the second operation, I undertook a third and last. The incision was made through the old wound. Here the tissues were an inch thick; hard and gristly. The hernia had been most effectually closed and the ends of the old suture could be plainly seen. Hemorrhage could only be controlled by sponge-pressure. On opening the peritoneal cavity, the trouble was at once apparent. A quart of foul fœtid pus was removed. The abscess cavity extended from the pelvis to the spleen. The intestines were crowded back and to the right and universally adherent, shutting off the abscess from the rest of the peritoneal cavity. Everything was covered with an apparent pyogenic membrane. The cavities were all thoroughly washed out and four rubber drainage-tubes put in, one extending to the spleen and one into the pelvis, the other two off sideways into deep pockets. The incision was then closed with four sutures. Recovery from the anæsthetic was prompt. Pulse was 130; temperature, 101°. But the pulse was 100 and the temperature 100° the next morning, and she was very comfortable. The tubes were washed out twice daily. For the first time for weeks she was able to retain much food. She was given every twenty-four hours twenty grains of quinine, f℥viij of whiskey, one pint of beef-tea and a pint and a half of milk, together with a couple of eggs. She retained most of this, taking part of it by the bowel and part by the mouth. In spite of all that could be done, the pulse and temperature slowly, but surely increased, until the thermometer registered 103° and the pulse counted 120. She sank slowly, and died the evening of the 24th, six days after the last operation.

No post-mortem was allowed, but on pretense of removing the drainage-tubes, the incision was enlarged and my hand introduced into the peritoneal cavity. Breaking up the adhesions surrounding the abscess cavity, I found there had been a slight general adhesion of all the intestines over the whole abdomen to everything. The liver and spleen substance were surprisingly firm. No more abscess cavities were found. The general appearance of the abscess walls was that of returning health: the pyogenic membrane had disappeared, and the peritoneum was beginning to look somewhat like itself. There was fairly good union in the incision, but it broke down readily under pressure.

In looking back over the management of this case, I recognize a number of fatal mistakes, and have learned some valuable lessons which I hope I may never have to relearn at the same cost. In the first place, all ovarian tissue should have been removed at the hysterectomy. However much I regret not having done this, there was at the time sufficient reason to justify leaving what little was left, especially as I thought the *serre nœud* was below it, and that it would all come away with the stump. I do not yet exactly see why it did not do so. The great error was in not being more careful in disinfecting the site of the old pedicle, which had never ceased to weep, before opening the peritoneal cavity a second time. The peritoneum undoubtedly became infected from this point during the necessary manipulations incident to the operation, and went on to a purulent peritonitis. Nature made a grand effort, even then, to save the patient, by throwing out adhesions as the inflammatory process advanced, and finally succeeded in saving half the cavity from involvement. After doing this, she gave all the indication

in her power as to what was the trouble, and by thrice discharging pus, apparently called loudly for assistance, which she failed to receive until it was too late.

Dr. H. A. Kelly said that he was sorry to say that he had required many lessons to teach him what Dr. Baldy hoped to have learned from this one experience. If anything went wrong which he could not attribute directly to the formation of stitch hole abscesses, and these did not cause any profound disturbance beyond a sudden rise of temperature, he did not hesitate to enter the peritoneum, with great care. On several occasions he had opened the peritoneal cavity five, six or seven days after operation, and in a case of day before yesterday, two weeks after the original operation. He usually does this without an anæsthetic or at most a few whiffs of chloroform, or cocaine locally. Cases requiring this have generally had a drainage-tube used and can be readily reopened in the track of the tube. The case of day before yesterday was a pyosalpinx, which had done well for ten days, and then the temperature and pulse began to rise. After giving a whiff of chloroform he introduced his little finger into the opening and penetrated to the floor of the pelvis when a collection of blood intermingled with pus made its escape. This did not seem sufficient to account for the symptoms, and by further bimanual examination he detected fluctuation on the right side, and with his finger broke through a thin wall and let out a teacupful of very fœtid pus. This was then washed out with his two-way catheter and a rubber drainage-tube inserted. Since then he has had his finger through that opening a number of times, for it has a great tendency to close. The case of Dr. Baldy's was instructive from the fact that it showed that there was a certain number of cases in which there is *dry peritonitis*, and the patients will sometimes die in spite of all treatment.

Dr. William Goodell said that he congratulated Dr. Baldy on the courage he had shown in the treatment of his case, and he thought he had nothing to regret. He always felt a good deal of reluctance in reopening the peritoneal cavity, but he had to resort to it occasionally. He did not think that the best method of curing the hernia had been employed. In his opinion the most satisfactory plan is, after dissecting out the sac and thinned-out tissues, to close the opening with three series of sutures. The first unites the peritoneum alone with a continuous gut suture. The second, also of gut, sews together the divided edges of the tendon. The third, of silk and interrupted, penetrates deeply through all the tissues but that of the peritoneum, and brings the edges of the skin and muscles together. The reason that we get hernia is that we fail to unite the tendon. To avoid the occurrence of hernia he had often thought it would be a better plan to cut through one of the recti muscles, instead of the linea alba, for then we have a broad raw surface. He occasionally resorted to this plan in oöphorectomy, but it has the objection of being accompanied with more hemorrhage. In large ovarian tumors the recti muscles were so widely separated that he was *per force* compelled to cut through their tendon, at the same time he admitted that he did not ordinarily unite these edges by a separate suture as is the custom of some excellent operators in this country. His reason is that this takes a good deal of time and it is always desirable to close the wound as soon as possible. But occasionally in cases of large ovarian tumors, he cuts away a long strip of the thinned tendon on either side of the wound so as to bring the muscles close together. In a certain number of cases, however, hernia will occur, and this was one grave objection to the use of the drainage-tube.

Dr. Parish asked if Dr. Baldy thought that the hernia was caused by the extra-peritoneal method of treating the stump?

Dr. Baldy said that the hernia was not due to the method of treating the stump. It began several inches above the stump and gradually extended towards it. He had, however, seen cases in which it occurred at the site of the stump, and he thought that this could not always be avoided on account of the large size of the pedicle and the subsequent contraction. He was glad to be able to criticise such a case in his own practice, as he could do so with more freedom than if it had happened to another. He thought it was his own fault that he had lost the patient. There were certainly enough symptoms to indicate the necessity for reopening the abdomen even a third or fourth time. The symptoms continuing after the first discharge of pus should have settled the question of reopening without any more delay. After the second discharge of pus he could not see why he had been so blind as to his duty. The patient would undoubtedly have recovered had the belly been opened early enough. Even as it was, after the long delay, she struggled along for about a week, but she was so thoroughly saturated with septic poison that she had not sufficient vitality left for the fight. He would not approve such a

policy of waiting in another, and could only excuse himself on the ground of lack of experience in such cases.

NEW YORK ACADEMY OF MEDICINE.

Stated Meeting, May 3, 1888.

The President, A. JACOBI, M.D., in the chair.

DR. A. R. ROBINSON read a paper entitled,

Some Studies on the Sweat Glands.

The following were his conclusions: 1. Sweat glands commenced to form at the tenth week of fœtal life instead of in the fifth month, as stated by Kölliker.

2. At four and a half months the coil and lumen partly formed, instead of at the sixth or seventh month, as stated by writers generally.

3. Some ducts communicated with the free surface at four and a half months instead of at the seventh month.

4. The lumen is not formed by breaking down of epithelia, but by a process of secretion, the product collecting between the cells.

5. No cuticula, or lining membrane, existed in the secreting part of the gland, and this structure was not composed of endothelia. It was often present in the epidermis as far as the granular layer, and consisted of the footplate of the epithelia.

6. But one row of epithelium lined the excretory duct until the rete prolongation was reached.

7. The muscular layer is not derived from epithelium, and is situated between the membrana propria and the epithelium when forming a continuous layer, and when fibres are isolated a few might be in the capsule.

8. The sweat glands secrete not only fat, but also sweat. Proof of this was offered in a study of several pathological lesions.

9. Milaria rubra and milaria alba are forms of milaria crystalina or sudamina.

10. Lichen tropicus is a form of eczema situated around a sweat duct and associated with hyperidrosis.

11. Milaria crystalina (sudamina) is an exudative affection depending on a neuroparalytic congestion, and not a sweat gland disease.

12. There is an adenitis sudoripara resembling somewhat eczema or dysidrosis in clinical character.

13. There is a cystic disease of the sweat ducts with distinct clinical characters.

A description of the pathological findings in these several diseases was given, and went to show that the function of the sweat glands was not alone to secrete fat, as stated by Unna, but that they had the additional function of secreting sweat, the view which had generally been accepted.

DR. HEITZMAN did not regard the proof brought forward by Unna and others as to fat being secreted by the sweat glands convincing. He thought the muscular layer of the sweat glands lay external to the membrana propria.

Action on the proposition to extend the territorial area of membership of the Academy was postponed.

PERISCOPE.

Behaviour of the Blood in Ligatured Vessels.

Böttcher's researches on this subject, conducted according to the latest histological methods, are to be found in the *Arbeiten aus dem pathologischen Institut zu Königsberg.* They fully confirm the conclusions of Dr. Guterbock, also those of Professor Pick, of Prague, on the processes which occur in the (so-called) organization of thrombi. Böttcher finds that the blood contained in a portion of a vessel intercepted between two ligatures, applied under antiseptic precautions, does not coagulate. The changes which occur in the stagnated blood are as follows: 1. Arterial blood becomes venous in character by long standing. 2. The red corpuscles may remain perfectly intact, even after the circulation has been suspended for several weeks. 3. The leucocytes early undergo degeneration, even in a week, but their nuclei preserve their capacity for stains. 4. The blood-tablets may be found in well-preserved condition, even after several days' stagnation. Finally, enumeration of the various forms of leucocytes in rabbits' blood led to the conclusion that the "lymphocytes," that is, the small, uninucleated forms of leucocytes, poor in protoplasm, represent the majority of the leucocytes existing in the blood. This is contrary to the prevailing assumption on the subject, which puts these very forms in the minority. This is a point, as Guterbock remarks, of great importance in the study of the products of chronic inflammation, the leucocyte elements of which are mostly in the form of lymphocytes, as is well known, and this circumstance has been adduced as an argument against the hæmatogenous derivation.—*British Med. Journal,* January 21, 1888.

Early Rising and Longevity.

Professor Humphry's recent Collective Investigation Report on Aged Persons, contains some very positive evidence on a matter which has already engaged the attention of moralists as well as physicians. "The opportunity for nutrition to do its restorative work was in nearly all provided by the faculty of 'good sleeping,' to which was commonly added its appropriate attendant, the habit of 'early rising.'" Thus there is a relation between early rising and longevity. No doubt many people will hastily seize upon the sentence just quoted, and employ it in edifying lectures or essays for the perusal of youth, or embody it in popular medical works. Important qualifications follow in Dr. Humphry's report, but they are likely to be overlooked. Doubtless the habit of early rising is, in itself, healthy; most of all, it is a good sign of health when it evidently signifies rapid recovery from fatigue. Again, it usually denotes a strong will, the gift as a rule of a good physical constitution, or at least the safeguard of average bodily strength. Late risers are generally either invalids or persons of bad habits, idlers who are never free from other vices besides idleness. The nervous exhaustion which keeps a man wakeful thoughout the small hours produces sleep late in the morning. This exhaustion is invariably due to one of several life-shortening influences, especially anxiety or indiscretion in diet or drink. Early rising is thus rather one effect of certain favorable influences, another result of which is longevity, than a cause of longevity. To turn a weakly man out of bed every morning at 7 o'clock will not prolong his life. It will be noted that by "good sleeping" Professor Humphry signifies quick sleeping, "that is, the reparative work which has to be done in sleep is done briskly and well." Here, again, we have an effect of a cause; but preventing a weakly subject from sleeping more than four or five hours nightly would not cause him to live long, but would rather tend to shorten his life. Equally important are Professor Humphry's observations which show that by "early" he does not entirely mean the time by the clock. The word "has a relative significance with reference to the time of going to bed. A person who retires to rest four hours after midnight and gets up at 10 A.M. may be strictly regarded as an 'early riser.'" Thus, early rising is synonymous in long life histories, with short sleeping, which means rapid recovery from fatigue, a sign of bodily strength. These scientific facts in no wise contradict the alleged value of early rising as a practice to be cultivated by all persons in good health. It is excellent as moral discipline, and eminently healthy as a matter of fact. Most persons will eat three meals daily. When a man gets up late those meals will probably follow each other at too short intervals to be wholesome. When he is an early riser it will probably be otherwise. He can enjoy a good breakfast, and by the time for his lunch or mid-day dinner he will have an honest appetite again.—*British Medical Journal*, March 31, 1888.

Intra-Uterine Dentition.

In the *Boletin Clinico* of Lerida, Señor Lorens mentions a case of intra-uterine dentition. He recently attended a woman in humble circumstances in Barcelona during a premature confinement at six months. The child had already cut the four incisors and the two lower canines. Had the woman gone her full time the dentition would have probably been much further advanced.—*Lancet*, March 10, 1888.

Borofuchsin as a Stain for Tubercle Bacilli.

Professor Lubimoff describes in the *Meditsinkoe Obozrenie* a new stain for tubercle bacilli, which he calls borofuchsin. It consists of:

℞ Fuchsin.....7½ grs.
Boric acid.....7½ grs.
Absolute alcohol.....4 drachms.
Distilled water.....5 drachms.

When prepared in this way it has a slightly acid reaction; it is quite clear and not liable to spoil by being kept, and consequently it is always ready for use. The sputum is dried on a cover-glass and stained by being heated in contact with the borofuchsin for one or two minutes. The stain is then washed out by treatment with dilute sulphuric acid. The specimen is then washed with alcohol, and subsequently immersed for half a minute in a saturated alcoholic solution of methylene blue. After being washed in distilled water and dried, the examination of the specimen is made in oil of cedar or in a solution of Canada balsam. In exactly the same way sections of tuberculous organs may be stained after hardening in spirit, only in such cases the steps of the operation must be somewhat more prolonged. The main difference between this and other staining processes for Koch's bacilli is that, when borofuchsin is used, the process of washing it out with sulphuric acid is an almost instantaneous one. All other bacilli are, as when other stains are used, rendered colorless and invisible, the tubercle bacilli alone being seen.—*Lancet*, April 21, 1888.

Treatment of Empyema.

At the meeting of the Harveian Society of London, March 1, 1888, Mr. Mansell Moullin read a paper on the surgical treatment of empyema, based on an analysis of thirty-four cases. In sixteen of these a discharging thoracic sinus was already present. He pointed out that the primary cause of the collapse of the lung was the accumulation of fluid; but that the permanent cause of its non-expansion when the pressure was relieved was the alteration in the structure of the pleura and the lung itself, and that this alteration was the effect of the absorption from the irritating fluid in the cavity. When the air had already gained admission without drainage being perfect, so that the pus had decomposed, the thickening of the pleura was much greater and more obstinate than when the empyema had never been operated on at all. Everything pointed, except in children and tubercular cases, which were expressly excluded, to operation as early as possible. Primary resection of a rib was hardly ever required, unless the empyema was loculated; india-rubber tubes very soon wore the ribs away, so that there was little chance of their being nipped as the thorax collapsed. Two tubes must always be inserted, even if they were only a few inches apart; they might be in the same intercostal space, but there must be two for effective drainage. The most convenient situation was the one usually adopted, in the fifth or seventh interspace in the mid-axillary line. Washing out the cavity was quite unnecessary; if air was allowed to pass freely in and out there was no decomposition; the amount of pus discharged diminished almost to nothing, and the cavity rapidly closed in. In old cases the first thing was to establish free drainage by making a second opening; on five occasions it was necessary to trephine the ribs, as the wall of the chest had practically become a solid bony cuirass. In two cases some of the ribs had been resected; in one, two inches of four had been removed, in order to allow the thorax to collapse, but the patient, who was already suffering from amyloid disease, sank from exhaustion ten days after. In the other, portions of only two ribs were excised, as the sinus ran rather round the thorax, following the direction of those ribs, than upwards as in the former case. This was attended with considerable benefit. No trouble was experienced from the intercostal arteries on any occasion. The direction in which the sinuses run must in each case determine where the ribs should be cut, how many should be removed, and how much of each. Dr. Phillips criticised the view that an operation should be performed early. He had seen good results follow from aspiration. He also thought that two openings were not essential, and was prepared to show cases which had made a steady recovery after one. A hard-and-fast rule as to the best place for the opening could not be laid down.—*Brit. Med. Journal*, March 17, 1888.

Prognostic Significance of Blood Pressure in Acute Renal Disease.

In a paper read before the Medical Society of London, March 5, 1888, Dr. Broadbent said that though high arterial tension was present in almost every form of kidney disease, yet he had twice seen low tension when symptoms of renal cirrhosis were present. In acute renal dropsy, when the pulse beats were short and easily arrested, it indicated temporary dilatation and weakness of the left ventricle; from this the heart afterwards recovered. A continued defect of tension might be due to persistent cardiac weakness, and this latter was of unfavorable prognostic import; in other cases it indicated diminished peripheral resistance, and this also was of bad augury. He quoted the case of a carman of sober and steady habits, who was admitted into St. Mary's Hospital with acute renal dropsy of four days' duration. His mother had been of intemperate habits, and he had undergone privation two years previously, but no exciting cause of the attack could be found. He had swelling of the face, scrotum and extremities, a bad cough, and solid, albuminous urine, containing epithelium and casts. The temperature was subnormal; the pulse 64, short and weak. The first cardiac sound was short, the second weak, and there was extension downwards of dulness. Dr. Broadbent pointed out that the most certain cause of albuminuria was the languid movement of blood in the renal capillaries, and the indication here was to improve the circulation. Under a mixture of iron, sulphate of magnesia, nux vomica and digitalis, the dropsy diminished, the pulse became of better volume and not so compressible, and the albumin diminished to a little more than a trace. The patient was allowed to get up too early, and this brought about a temporary increase in the albuminuria. The imperfect development of blood pressure showed the nature of the patient's constitution, and might be made use of in prognosis. It indicated a long illness, and the necessity of the use of vascular stimulants.—*Lancet*, March 10, 1888.

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THE IMPROVEMENT OF MEDICAL EDUCATION.

At the last annual dinner of the Alumni of the Medical Department of the University of Pennsylvania, the Provost, Dr. Pepper, made a speech in which he described the advances made in the University during the last ten years toward a fuller and better system of medical education, and the hopes entertained by the Alumni and the Faculty that still further advances would be made in the near future. The success with which the University has maintained the system of an obligatory three years' graded course and longer annual terms has encouraged its friends to hope that very soon the period of study may be increased to four years. This hope is in the line of the wish of many advocates of higher medical education in the United States, as voiced by Dr. Garnett in his Presidential address at the last meeting of the American Medical Association, in Cincinnati. But we believe it is by no means certain that the object of this hope is likely to be reached very soon. The few institutions in this country which have so far adopted and adhered to the system of a three years' graded course have done so at considerable risk, and with a material diminution of the number of their students; and one of the most popular and widely known medical schools in America suffered so much in consequence of a step of this kind that it was compelled to go back almost immediately to the old two-term system. It cannot be said that the three years' system has yet established itself firmly, and we fear that an attempt to inaugurate a four years' system might not only fail of success, but actually imperil the stability of what seems now to be on the way to success.

At the dinner referred to, Dr. Alfred Stillé, Dr. Traill Green and Dr. William Hunt also spoke, and all of them urged the importance of making sure of a firm footing before attempting any further advance, and all seemed to feel that an attempt to establish very soon a curriculum covering four years of study within the walls of a medical school would be hazardous to the cause of higher education.

This feeling we know to be shared by many men who regard with satisfaction what has already been attained, and who hope to see still more accomplished. As we understand the matter, the things to be urged most strongly upon the medical schools of America just now are: first, the general exaction of an honest and adequate preliminary examination of those who propose to study medicine; and, second, the general adoption of a three years' course of intra-mural study. If these two things could be secured, the improvement in medical education would be enormous—far greater, we believe, than would be gained by the adoption of a four years' course by a few schools. For this reason, we believe that the friends of higher medical education would do well to devote their energies to persuading, or—if need be—compelling, all the medical colleges of the United States to adopt these measures, which a few have shown to be both desirable and feasible, rather than to widen the gap which even now separates the best schools from those which secure the largest number of students.

But there is another measure which, if it were adopted, would simplify very much the question we have been considering, and almost do away with the necessity for insisting on uniform conditions of study. This is the enforcement by law of a suitable examination by State or National Boards of candidates for a license to practice medicine. If this were secured, we believe all questions of medical education would soon be satisfactorily settled. Then the schools which furnished the best means of education would secure the largest number of students, and good education would be at a premium, instead of cheap and easy graduation.

For the present then, we believe the friends of higher medical education ought to labor most earnestly to have medical schools restricted to the work of educating their students, and to put the right to issue licenses in the hands of examiners who are not connected with the schools at all. This is the most urgent need just now, and to this we invite the thoughtful attention and active cooperation of our readers. Let them in their County and State Societies labor with earnestness and patience for the establishment of State Examining Boards, and we believe that before long the problem of medical education in the United States will be fully and satisfactorily solved.

ECTOCARDIA.

Among all the anomalies of development in human beings, none is more curious or more interesting than that in which the heart occupies an abnormal position or is devoid of its usual coverings. As long ago as 1826, Breschet published in the *Répertoire Général d'Anatomie et de Physiologie Pathologiques*, a paper on such anomalies, and a few years later Geoffroy Saint Hilaire included this subject in his admirable work on teratology. A number of cases have been reported in which the heart was in a situation more or less removed from the normal one, and exposed to view because of the lack of development of its coverings. In all of these cases, until very recently, death soon followed the birth of the child. But the *Bulletin Médical*, May 9, 1888, contains a paper read by Professor Lannelongue before the Académie de Médecine on May 7, reporting a case of this sort, in which he performed a plastic operation, and had the satisfaction of seeing his little patient recover and survive. This interesting case concerned a little girl six days old, when she was brought to Prof. Lannelongue, Feb. 15, 1888. She had a defect of the upper and middle part of the sternum and the overlying soft tissues, which left the ventricles of the heart exposed. The defect was about as large as a quarter dollar piece. At the time when she was first seen by Prof. Lannelongue there was a sort of membrane almost covering its heart, which presented a gangrenous appearance, and which soon sloughed away. After instituting some physiological investigations of the action of the heart, and waiting nine days to mature his opinion as to what should be done, Prof. Lannelongue closed the gap by a plastic operation, consisting in making two vertical incisions parallel to the long axis of the opening, and about half an inch from each edge, loosening the slips of skin, and sliding them toward the median line, until they could be united with three points of silk suture. Good, but not immediate, union followed, and in less than twenty days the whole surface was cicatrized and the opening closed.

The story of this case is of more than ordinary interest, because it furnishes a happy illustration of the result of a rare condition coming under the care of a man thoroughly competent to treat it. The history of the case does not indicate how it happened that the child was six days old before it was brought to the notice of a surgeon, and it is only just to our French brethren to suppose that the infant was born under the guidance of a midwife, and not of a physician. When the child was brought to Prof. Lannelongue, it was subjected to an operation so simple and so easy of performance as to reflect credit upon the judgment of the surgeon, but one which was hardly so remarkable as to justify the pride which it

seems to have excited in the hearts of his fellow Academicians.

In fact, while the operation was undoubtedly judicious and deserving of imitation, the interest of the case is largely that which attaches to its rare and curious nature, and—we venture to say—to the questions of embryology and physiology which it suggests. It would be useful to learn several things which are not stated in the report, for example: the appearance of the defect when the child was born, the character of the membrane which sloughed off, and the part borne by the process of ulceration in producing the complete defect. Finally, the exceedingly interesting report given by Prof. Lannelongue might be regarded as more complete if he had discussed the feasibility of some method of assisting nature to bring together the separated halves of the sternum.

These reflections suggest lines of thought which we cannot now follow out; but we commit them to our readers for their own pursuit. Certainly the case we are considering is rare and curious enough to engage more than passing attention.

THE AFTER-TREATMENT IN CATARACT OPERATIONS.

At the meeting of the American Medical Association, in Cincinnati, May 8, 1888, Dr. Julian J. Chisolm read before the Ophthalmic Section a paper describing the simple dressings used at the Presbyterian Eye and Ear Charity Hospital of Baltimore, after operating for cataract. From May 1, 1887, to May 1, 1888, Dr. Chisolm has treated seventy-four cases of simple senile cataracts. All of these were operated upon in the operating-room of the hospital, on a high, narrow table, and before large windows. In every case the biniodide of mercury solution (1 to 20,000) was freely used, both before and after the operation, as an antiseptic wash. After the operation for cataract extraction he has closed only the eye operated upon with a piece of white isinglass plaster, leaving the other eye open. None of the patients were put to bed. They were kept in a moderately lighted room, and were allowed to lie, sit or walk about as they wished. They dressed themselves, took their regular meals, received their friends daily, and had as little restraint imposed upon them as possible. The isinglass strap was inspected daily. It usually remained firmly adherent until the fourth or fifth day, when it was removed. As it was diaphanous, the condition of the eye-lids and eye secretions could be readily examined. Should the eye be painful at any time an atropia drop could be introduced by capillary action from the inner canthus. Salicylate of sodium was also given in twenty grain doses to sooth the eye and the patient. After four or five days the strap was removed and the eye left exposed. No smoked glasses were used, and none were needed. Dr. Chisolm has shown by his year's experience that if one eye is left open the other never becomes sensitive to light. When the strap is removed there is no weeping and injections, with photophobia—as is always seen when the patients' eyes have been dressed by bandages and they have been kept in dark rooms. The conclusion forced upon Dr. Chisolm is that most of the annoyances which follow upon cataract operations when the double bandage is used, do not depend upon the traumatism of the eye, so much as upon the too confining dressings. With seventy-four simple senile cataracts operated on during the year, not an eye has been lost. In every case a clear cornea has been preserved. In only two cases were the pupils closed from iritis, which will necessitate an iridectomy for the restoration of good sight. In no case was there suppuration. Dr. Chisolm's opinion is that when the operation of cataract extraction is smoothly done, and with every antiseptic precaution, it matters little what kind of after-treatment is adopted—good sight in every case is practically assured. If such results follow his method, then the annoying restraints heretofore practiced by all, and still used by many operators, are uncalled for.

During the discussion of the paper, many specialists present at the meeting endorsed Dr. Chisolm's conclusions, having adopted his method of light dressings with freedom of movements to the patient.

This method is one which seems, therefore, to be approved by experience, and to have decided advantages over those which were formerly considered necessary. To the patient it must be no small gain to be free from the disagreeable restraint of the bandage, and to be able to enjoy the pleasure of vision after operation, as well as to seem to himself and to his friends less an invalid than is possible with bandaged eyes and in a darkened room; while to the surgeon it must be a great satisfaction to know that this freedom from restraint is not gained at the cost of an increased risk, but rather contributes to a speedy and safe recovery.

WOUNDS OF THE PALMAR ARCH.

At a meeting of the *Société de Chirurgie*, of Paris, May 2, 1888, M. Bosquet reported a case in which the palm was severely cut with a fragment of a bottle, so that the flexors of the thumb and index were completely divided, and there was a profuse hemorrhage. After trying in vain, and for a long time, to ligate the divide vessels in the palm, M. Bosquet ligated the radial and ulnar arteries, presumably in the wrist. After this communication had been read, M. Championnière expressed the opinion that good compression would have controlled the hemorrhage and obviated the necessity for the operation of ligation in the wrist. To which M. Bosquet replied that he had feared to use prolonged compression on account of the pain it would cause.

We call attention to this occurrence because it indicates what we believe is a widespread error in regard to the treatment of wounds of the blood-vessels in the palm. Most works on surgery and most surgical teachers advise having recourse to ligation of the radial and ulnar arteries, when ligation at the original wound is very difficult, in a way which appears to do injustice to what can be accomplished by local compression; and M. Bosquet evidently ignores the value of compression, while M. Championnière appreciates it fully.

As a matter of fact, we believe that few wounds of the palm absolutely require ligation of the vessels in the wound, or anywhere else. And we think that the rule of practice ought to be: ligate in the wound, if this can be done without prolonged or laborious effort; and, if not: elevate the part and apply a compress which has been soaked in cold water, or some mild astringent, and then squeezed fairly dry, binding it on with moderate, but not excessive, firmness, and maintaining the hand in an elevated position. No one who has not tried it would believe how much can be accomplished by a rational use of elevation and moderate compression in the case of wounds of even quite large arteries; and we believe that distant ligation should never be appealed to until the method just described has been fairly tried. Certainly in wounds of the palm much trouble to the surgeon and some risk to the patient might be avoided if it were thoroughly appreciated.

CATHETERIZATION OF THE URETERS.

Catheterization of the ureters has lately been brought into prominence by several writers, and the subject is unquestionably one of great promise and importance. Its range of application too, is by no means so limited as would first appear. It can not only be used as a diagnostic measure, but it is also a most valuable aid in the treatment of urethritis, pyelitis, and sacculation of the pelvis of the kidneys and ureter. By means of this operation the urine from each kidney can be separately collected for examination, and the relative condition of the two kidneys can be much more accurately diagnosticated than has heretofore been possible. In cases of stone in the kidney or its pelvis, or other morbid condition, when nephrectomy or nephrotomy is indicated, the value of this method in deciding which kidney is diseased is apparent. We are not aware, however, that this has been applied in practice, except in the case of Iversen mentioned in our editorial in the REPORTER, May 19, 1888. By the use of the renal sound, stone in the ureter or renal pelvis can be diagnosticated. Thus far catheterization of the ureters has been principally employed in the treatment of catarrh or sacculation of the ureter and pelvis

on, the fistula has been the result of traumatism, in others, it was made intentionally to insure drainage, and to facilitate catheterization. In the male, preliminary or supra-pubic cystotomy, would be necessary; but, since catarrh and dilatation of the ureter and pelvis of the kidney are usually secondary to cystitis, this is hardly a contraindication, especially when the very serious nature of the conditions is considered.

ACKNOWLEDGMENT.

We take pleasure in acknowledging our indebtedness to the reports published in the daily issue of the Cincinnati *Lancet-Clinic* for a part of our report of the proceedings of the last meeting of the American Medical Association. The work of our own special reporters was admirable, but by adding to it some extracts from the *Lancet-Clinic*, we have been enabled to present our readers with a report which was prompt, and, we believe, accurate, and which we trust will prove satisfactory to them.

—The *Ledger*, May 29, 1888, says that M. Oscar Schmidt, professor at the University of Gratz, in Styria, has discovered a method by which pieces of living sponge can be broken off and planted in a favorable spot. From very small cuttings of this kind Professor Schmidt has obtained large sponges in the course of three years, at a very small expense. One of his experiments showed that the cultivation of 4000 sponges had not cost more than 225 francs, including the interest for three years on the capital expended. The Austro-Hungarian Government has been so much struck with the importance of these experiments that it has officially authorized the protection of this new industry on the coast of Dalmatia.

Book Reviews.

[Any book reviewed in these columns may be obtained, upon receipt of price, from the office of the REPORTER.]

QUESTIONS AND ANSWERS ON THE ESSENTIALS OF PHYSIOLOGY. PREPARED ESPECIALLY FOR STUDENTS OF MEDICINE. By H. A. HARE, B.Sc., M.D., etc. With Illustrations. 8vo, pp. 170. Philadelphia: W. B. Saunders, 1888.

This book differs from most works intended for the use of medical students in that it imitates the style of the quiz class, being prepared in the form of questions and answers. The matter—as might be expected from the reputation of the author—is most excellent. The manner is dogmatic and well suited to the needs of the student preparing for examination. The author justifies his method by citing the existing state of medical education in this country, and some of his statements by the fact that physiology is a branch of science in which change is constantly occurring, so that a definite answer to certain questions is not unlikely to differ from the opinions of some authority. The needs of medical students, however, necessitate definite answers, and those given in this book represent very well the present state of knowledge in physiology.

A TREATISE ON FRACTURES AND DISLOCATIONS. VOL. II.—DISLOCATIONS. By LEWIS A. STIMSON, B.A., M.D., Professor of Clinical Surgery in the University of the City of New York, etc. Large 8vo, pp. 541, with 163 illustrations. Philadelphia: Lea Brothers & Co., 1888. Price: cloth, $3.00; leather, $4.00.

This is a very handsome and complete treatise on dislocations, and a fitting companion to the volume on fractures issued some time ago by the same author. Dr. Stimson has had a large and varied experience in the treatment of dislocations, and is thoroughly familiar with the opinions and methods of other surgeons in this country and in Europe. As a consequence, the volume before us will undoubtedly add to his reputation as a surgeon and as an author, and it can be recommended to our readers as a safe guide in practice. If we were to offer a criticism, it would be that, in the fulness of his descriptions, he has included some methods which are hardly other than surgical curiosities, and which are neither necessary to success nor indeed practicable for most surgeons. Still this adds to the completeness of the book, and does not detract from its merits.

MEMORANDA ON POISONS. By THOMAS HAWKES TANNER, M.D., F.L.S. Sixth American, from the last London Edition. Revised by Henry Leffmann, M.D. 32mo, pp. 177. Philadelphia: P. Blakiston, Son & Co. 1888. Price, 75 cents.

This admirable little book has been so long and so favorably known to the profession that it is not necessary to speak particularly of its merits. But to those who are not already familiar with it, it may be worth while to say that it is a compact and handy manual of the treatment of poisoning, arranged in such a way as to be a ready reference book for emergencies of this sort. It is a good book for students of medicine to carry in their pockets, and not a bad one for any practitioner.

Literary Notes and Queries.

[In this column the Reporter will publish short items of literary interest and questions addressed to this Journal or its readers, and answers to them, in regard to any literary matters: books, authors, places and prices of publications, etc.]

—The prospectus of the *Texas Health Journal*, just received, announces that it is to be published as a monthly magazine, each number to contain thirty-two pages of reading matter devoted to the education of the people of that vast State in matters of sanitation, preventive medicine and dietetics. The editor is Dr. J. R. Briggs, and the place of publication, Dallas, Texas. The subscription price is to be $2.00 a year. The object of this journal is one deserving of hearty commendation, and it has our best wishes for its success.

—The publication of a new journal, entitled *Revue sur les Malaaies du Système Nerveux*, under the direction of Professor Charcot and M. Paul Richer, is announced. It will contain clinical observations and a descriptive account of the diseases of the nervous system observed at the Salpêtrière, in Paris.

Correspondence.

Appendix Vermiformis.

Editor Med. and Surg. Reporter:

Sir:—I notice in the Reporter, May 12, 1888, page 587, that Dr. Gaston says that the appendix vermiformis is not found in the lower animals, with the exception of some of the monkey tribe. In this he is certainly mistaken. It is present in the horse, sheep, chicken, and I think in the hog. I lost a valuable horse from strangulation of the small intestines, caused by the far extremity of the appendix adhering to the colon, forming a loop in which the constriction took place. I have always understood that condoms were made from the blind gut of the sheep. And as to the appendix in the chicken, I am very sure of that, having used them frequently in making a sac of thin peritoneal coating to be used in plugging the nose to stop hemorrhage.

Yours truly, A. Ady.

Muscatine, Iowa, May 17, 1888.

Formula for Paraldehyde.

Editor Med. and Surg. Reporter:

Sir:—I have occasionally desired a hypnotic for cases in which it was not advisable to administer any preparations of opium nor chloral hydrate. Paraldehyde appeared to act favorably in nervous irritability, or even cerebral exhaustion, as well as hyperæmia and insomnia, especially the latter; but it is a substance quite unpleasant to swallow. As the result of several experiments, I offer the following formula, which I have found quite satisfactory:

Paraldehyde	3 ij
Tinct. cochineal	3 ij
Spirits of nitre	3 ij
Water	3 iv

After standing a short time it loses some opacity and becomes clear. A few drops of tincture of cochineal is advisable to color. Alcohol may be substituted for the spirits of nitre, but in cases, requiring a rather large dose, might not be advisable. If any one can furnish a formula superior to the foregoing it would be a favor to do so.

Allen A. Rawson, M.D.

Corning, Iowa, May 10, 1888.

"Wasted Sunbeams—Unused House-tops."

Editor Med. and Surg. Reporter:

Sir:—I thank you for your editorial notice of a recent article of mine under the above heading—believing it to be a subject worthy of wide consideration.

I made two special points. First, a rearrangement of the upper floors of dwellings, so that "solaria" might be afforded for use in winter by children, invalids and others in the colder months. Second, a utilization of roofs as "home parks" in our cities. Allusion was made to ancient usages in these respects, with the suggestion that architects and sanitary science adapt such usages to modern homes and present civilization. The paper was suggestive; and though having well-defined designs of construction in my mind, left details for architects to define, as being best adapted to varieties of dwellings. Having consulted civil authority and the highest architectural and sanitary experts in regard to the feasibility of my suggestions, I can speak most cordially on the subject.

A recent writer in one of our great dailies, speaking from a practical knowledge of the subject, said: "The Board of Health, if necessary, could as readily regulate this matter of 'home parks' as it can other matters relating to the public health." * * * "Architecture and sanitary science are fully equipped to undertake the grand hygienic innovation proposed. Dr. Smith's suggestions are perfectly practicable, and if adopted, would add to the health, happiness and longevity of the people."

I thank you again for commending the ideas to the attention of your readers, "in the

hope that some of them may be able to suggest a plan by which they can be carried out."

Yours truly,
GOUVERNEUR M. SMITH.

14 East 17th St., New York City,
May 21, 1888.

Prescription for Headache.

EDITOR M[illegible] S[illegible] R[illegible]

In like conditions I have exhibited atifebrin, sometimes with success; less marked, however, than with antipyrin. Generally speaking, antifebrin seems to have a happier effect when the headache is occipital, and the heart's action rather weak.

In comparing the two, omitting, however, their relative sedative influence upon nerve tissue, the greatest advantage possessed by antipyrin over antifebrin is its *solubility;* which makes it of infinite value in malarial hyperpyrexia, accompanied by either coma or irritable stomach, or both, in which cases it may be administered hypodermatically.

Yours truly,
J. T. BRINGIER, M.D.

Burnside, La.,
May 15, 1888.

Electrical Treatment of Pruritus Ani.

EDITOR MED. AND SURG. REPORTER:

Sir:—Dr. Stanbury Sutton is, in my view, correct in his estimate of the neurotic origin of pruritus ani and its treatment. Galvanism and Faradism will cure it, especially if combined with sodium bromide in large doses, hypophosphites, arsenic and regular laxatives.

Static electricity is better than Faradic, and easier and cleaner in application. This trouble, and eczema, so often occur incidentally in neurological practice, and these patients sometimes come to us for relief after the dermatologist has failed, so that a neurologist must of necessity get considerable experience in its management. There is a special form of hyperæsthesia in pruritus and a vasomotor paresis which under static electricity disappear as if by magic. I have seen the reddened and irritated skin about the coccyx and perinæum in the affection become promptly blanched by one seance, and the patient go out of the office completely comfortable for hours after one treatment. This must be followed by nightly doses of from forty to sixty grains of bromide of sodium combined, etc., as above indicated and often repeated to secure relief.

Yours truly, C. H. HUGHES.

St. Louis, Mo.,
May 7, 1888.

NOTES AND COMMENTS.

Battey vs. Tait.

One of the most exciting scenes which occurred at the late meeting of the American Medical Association at Cincinnati, was the speech of Dr. Robert Battey, of Rome, Ga., in which he discussed the question of priority in the Battey (or so-called Tait) operation. He completely captivated the section and was greeted with cheer after cheer. Those who know Tait's arrogance and self-conceit enjoyed the speech exceedingly, and to one who had heard Tait stand up in the British Medical Association at Dublin, and call American medical men "tramp doctors," it was a treat ever to be remembered. There are about this country certain young gynecologists who have gone to Tait, paid their twenty guineas for a month's assistanceship, and must continually talk about their teacher.

In discussing the paper which brought the subject up, Dr. Battey said: The author seems to know nothing about American work, in his use of the term Tait's operation. Tait cares nothing about the change of life; he operates for pain, not disease. The author argues this change of life very strongly. There was a humble American surgeon, who before this time, away back in 1872, suggested this operation and described it; years before Tait was heard to speak on the subject. The author of the paper speaks of Tait's struggles in introducing this operation. The older members of the profession will remember the struggles of the operation in the Georgia State Medical Society, The American Medical Association, and the American Gynecological Association. This was going on for years,

and Tait said nothing until May, 1879. Are we to accept the simple say-so of Tait that he thought of this operation and said so to Dr. Chadwick of Boston? Dr. Chadwick does not remember it; he may have said it, but he cannot certify that he did. Why should Mr. Tait come in at the end of the fox-chase and claim the tail of the fox? I have sat too modestly in my chair and allowed Mr. Tait to talk about "his operation." I despise this little quibbling fight, but when a member of my profession in my own national association talks so much about "Tait's operation," it is too much. Mr. Tait has recently shown so much modesty in saying that possibly it might have been thought of before, that you would not recognize that it was Mr. Tait. [Applause.] I forbear to reveal the secrets of Mr. Lawson Tait's hospitality to me in 1881, but he may provoke me to do so. [Hear! hear!] A little latter while enjoying the hospitality of Dr. Mathews Duncan, that straightforward specimen of a Scotchman, he said to me that he had hoped not to be called upon to invoke the aid of this operation, but he had. What Dr. Duncan said of Mr. Lawson Tait, deponent saith not. [Applause.] Mr. Tait found it necessary to resurrect a patient at the Congress of 1881, who was recorded dead years before in his own hand-writing. When asked how about this, he said: "Only a little clerical error." May God forgive Mr. Lawson Tait and prevent me from falling into his ways. I had to go over and pitch the battle in the British Medical Association under the nose of Mr. Tait. He referred to Tait's paper—"Normal Ovariotomy"—in the *British Medical Journal* in May, 1879. The essence of my operation is the change of life; Mr. Tait does not operate for this, and here is the dividing line. Hegar's operation is the Battey operation; he claims nothing else. It is only his friends who call it the Hegar operation.

The 0.25 Dioptric Cylinder the most Valuable Lens in the Trial Case.

Dr. Julian J. Chisolm read a very practical paper on the above subject before the Ophthalmological Section of the American Medical Association at its recent meeting in Cincinnati. He quoted text-books to show that very few writers on refractive errors were disposed to recognize less than a 0.5 cylinder for the relief of eye pains, and that $V = \frac{20}{20}$ was considered incompatible with astigmatic errors. From his very large experience over many years, he is able to formulate the statement that painful eyes, although they possess $V = \frac{20}{20}$ can have low degrees of astigmatism, and that such is a common fault in the over-worked, painful eyes of students. During the last year he had prescribed glasses for 986 astigmatic eyes, 546 of which exhibited a fault of only 0.25 of a diopter, and yet this small degree of error would not permit these irritable, painful eyes to be used. The correction of the fault restored at once comfortable [illegible] their continuance for months have resisted the skilled treatment of physician and gynecologist, have yielded promptly and perfectly to the continued use of weak cylinder glasses. Dr. Chisolm says in his paper that the reason why specialists do not find these low degrees of astigmatism is that with their preconceived views of its non-existence they do not look for it. The result is that many patients who seek their advice with painful eyes go away unrelieved. As he is aware of its importance and of the great annoyance which a 0.25 D. astigmatism occasions, he is always on the lookout for it, and frequently finds it to the very great relief of his patients. He prescribes more 0.25 D. cylinder lenses than any other; as very decided benefit comes from their use, he is forced to believe that this, the weakest of all the cylinders of the trial case, is in practice the most valuable.

Anti-Vaccinators.

It is stated that the partisans of the medical doctrines opposed to vaccination are organizing a Congress to be held in Paris in September next. The aim of the anti-vaccinators is to show that vaccinal inoculation is of no effect in preventing small-pox in spite of what has been proved by statistics; that the improvement in public health is the sole cause of the diminution of epidemics, and they point out that the Jennerian lymph is only a syphilitic virus more or less pronounced.

Rectal Insufflation of Hydrogen Gas in the Diagnosis of Penetrating Wounds of the Abdomen.

In concluding his paper on this subject, at the the last meeting of the American Medical Association, Dr. Senn expressed himself as follows: After a careful study of the subject of rectal insufflation of hydrogen gas in its various aspects, I do not hesitate to recommend its adoption in practice as an infallible diagnostic test in demonstrating the existence of a wound of the gastro-intestinal canal in penetrating wounds of the abdomer, without resorting to an exploratory laparotomy. In conclusion, I beg leave to submit for your discussion the following propositions:

1. The entire alimentary canal is permeable to rectal insufflation of air or gas.

2. Inflation of the entire alimentary canal from above downwards through a stomach-tube seldom succeeds, and should therefore only be resorted to in demonstrating the presence of a perforation or wound of the stomach, and for locating other lesions in the organ or its immediate vicinity.

3. The ileo-cæcal valve is rendered incompetent and permeable by rectal insufflation of air or gas under a pressure varying from one-fourth of a pound to two pounds.

4. Air or gas can be forced through the whole alimentary canal from anus to mouth under a pressure varying from one-third of a pound to two pounds and a half.

5. Rectal insufflation of air or gas to be both safe and effective must be done very slowly and continuously.

6. The safest and most effective rectal insufflator is a rubber balloon, large enough to hold 16 litres (quarts) of air or gas.

7. Hydrogen gas should be preferred to atmospheric air or other gases for purposes of inflation in all cases in which this procedure is indicated.

8. The resisting power of the intestinal wall is nearly the same throughout the entire length of the canal, and in a normal condition yields to diastaltic force of from eight to twelve pounds of pressure. When rupture takes place it either occurs as a longitudinal laceration of the peritoneum on the convex surface of the bowel, or as multiple ruptures from within outwards at the mesenteric attachment. The former result follows rapid and the latter slow inflation.

9. Hydrogen gas is devoid of toxic properties, non-irritating when brought in contact with living tissues, and is rapidly absorbed from the connective tissue spaces and all of the large serous cavities.

10. The escape of air or gas through the ileo-cæcal valve from below upwards is always attended by a blowing or gurgling sound, heard most distinctly over the ileo-cæcal region and by a sudden diminution of pressure.

11. The incompetency of the ileo-cæcal valve is caused by a lateral and longitudinal distension of the cæcum, which mechanically separates the margins of the valve.

12. In gun-shot or punctured wounds of the gastro-intestinal canal insufflation of hydrogen gas enables the surgeon to demonstrate positively the existence of the visceral injury without incurring the risks and medico-legal responsibilities incident to an exploratory laparotomy.

Ether Drinking in Ireland

In some places in the north of Ireland ether is largely used as a substitute for whiskey, one reason being its cheapness, inasmuch as a person can obtain for a penny sufficient ether to make him drunk. The subject of ether drinking was recently brought before the General Synod of the Irish Church. A clergyman proposed that a petition be presented to Parliament praying for the suppression of the sale of ether as an intoxicant in certain districts; but as it was pointed out that ether was sold for other purposes than as an intoxicant, he substituted the word "regulation" for "suppression," and the motion as amended was adopted. There is a special kind of ether sold prepared for drinking purposes, and although the Excise authorities have been applied to, they have refused to control its sale.—*Lancet*, April 21, 1888.

Peculiarity of American Eyes.

The efforts of the War Department to secure a field glass of greater power than the one they now use, has disclosed the fact that the eyes of the average American are closer together than those of men in foreign countries. The double glass, known as the field glass, now used, is weaker than that used in the armies of Europe. The only glass they can get of sufficient power is a single spy-glass, which is defective, in that it does not take in a broad enough field. This is a very serious defect in the equipment of the American army, but there seems to be no immediate prospect of its correction, because our eyes are too close together. Some of the colored troops may be able to use a different glass, but the white soldier cannot overcome this national peculiarity.

Alcohol.

Prof. Atwater says in the *Century:* Among the curious side issues of the current temperance discussion is the question whether alcohol is a natural product. This is, I believe, vigorously denied in some quarters. Alcohol, like bread, is manufactured artificially from a natural product. In each case fermentation, a natural process, is made use of. But while bread is known only as a product of manufacture, alcohol appears to be very widely distributed in nature, though in extremely minute quantities. Nor is this at all surprising. If grapes or apples, or their juice, be exposed to the air, fermentation sets in and the sugar and other carbohydrates are changed into alcohol. The ferments which cause the change are afloat in the air all about, and might not unnaturally attack similar compounds in other vegetable substances. Prof. Muntz, of the National Agronomic Institute, in Paris, has, by refined chemical tests, discovered evidences of alcohol in cultivated soils, in rain-water, in sea and river water, and in the atmosphere. He finds that vegetable molds may contain considerable quantities, and it appears probable that the alcohol "originates in the soil, from the fermentation of the organic matters in it, and is thence diffused as vapor in the atmosphere." Another side issue of our temperance discussion is the so-called "Bible wine" theory, which maintains that the wine used in Palestine in the time of Christ was not alcoholic. I have been unable to find evidence that the composition of the juice of the grape, the laws of fermentation, or the practice in the making and using of wine were different in that country at that time from those in other countries, or in that country at other times; and believe it safe to say that the theory that Bible wine was different from other wine, that it had not the alcohol which other wines contain, is without any basis to support it, in the opinion of the student of science.

Olive Oil for Gall Stones.

At the meeting of the Berlin Medical Society, April 18, 1888, S. Rosenberg exhibited 629 gall stones which were discharged from a patient after he had been treated with large doses of olive oil, as lately recommended in America. Doses of from three to six ounces were given. The gall bladder, which before the treatment was of the size of a small fist, has become so shrunken that it can now scarcely be felt, while the previous extreme distress of the patient has considerably diminished.—*Deutsche med. Wochen schrift*, April 26, 1888.

Distilled Water.

In his valuable "Manual," Adolph Vomacka says: "It is not every water that is fit for use in the preparation of a pure distilled water, and certain it is that the so-called "distilled water," which is merely a by-product of other processes (condensation water from steam engines, for instance), is not fit to use in most of our pharmaceutical laboratory work. We must have for these, and especially for hypodermic injection solutions, an absolutely pure distilled water. To obtain this Vomacka recommends following the directions of the Pharmacopœia of the Netherlands, which are in effect as follows: Add to the water which you intend to distil potassium permanganate, so long as the violet color produced by each dosage is evanescent. When this is no longer the case, add a solution of alum until a weak acid reaction is obtained. Let the water stand until a precipitate no longer falls. Draw off the limpid portion and distil, throwing away the first and last thirds which pass over; in other words, distil one-third, and throw away the distillate; distil, and reserve for use only one-half the remainder. This distillate may be relied on as chemically pure. *National Druggist*, April, 1888.

Antifebrine Mixture.

The *American Druggist*, April, 1888, gives the following:

Antifebrine	60 grains
Brandy	4 fl. drachms
Water	6 " "
Syrup	6 " "

Dissolve the antifebrine in the brandy, then add the other ingredients. Dose, a teaspoonful.

Milk Jelly.

As a variation in milk diet, the following is recommended by Prof. Liebreich:

Heat 1 quart of milk with 1 pound of sugar, and when the sugar is dissolved continue the heat, at a boiling temperature, for about ten minutes. Now cool it well, and then add, *slowly* stirring, a solution of 1 ounce of gelatin in a cupful of water. Next add the juice of 3 or 4 lemons and 3 wine-glasses full of wine, brandy or other liquor. Set the glasses containing the mixture in a cold place, so that the contents may gelatinize. It is necessary to have the milk quite cold before the other ingredients are added, as it would otherwise curdle.—*American Druggist*, April, 1888.

Eye Inflammation dependent upon Lesions of Dental Branches of the Fifth Nerve.

In the *N. Y. Medical Journal*, April 14, 1888, Dr. F. W. Marlow reports three cases illustrating the dependence of eye-inflammation upon irritative lesions of the dental branches of the fifth nerve. The following is a summary of his paper:

1. The inflammation was most marked at the margin of the cornea. 2. The conjunctival affection was limited to congestion and slight swelling, there being no discharge of matter. It would thus seem probable that the conjunctival symptoms were simply secondary to the corneal. 3. The corneal affection was quite superficial, but extended over a considerable area. In the first case it much resembled that seen in inherited syphilis. In the two last cases there was a tendency to loss of epithelium. Thus it differed from the ordinary phlyctenular type of keratitis, which tends to be more definitely localized in one or more spots, and to be accompanied by well-marked ulceration and the development of blood-vessels on the cornea.

4. In all the cases there were variations in the condition from time to time, the symptoms never entirely disappearing (with the exception of those of the left eye in one case) in spite of the long-continued use of the usual local and general treatment.

5. When the dental irritation was removed the eye-symptoms disappeared rapidly and completely in each case, and so far without relapse.

There can be little doubt, he says, that the removal of the dental irritation and the disappearance of the eye-symptoms stood to one another in the relation of cause and effect, and he thinks it may fairly be said that the dental irritation aggravated and prolonged the eye-inflammation, if it did not, as indeed seems very probable, constitute the original exciting cause of the trouble. If we admit, he concludes, that the condition of the teeth influenced the eye trouble in any way in these cases, it becomes evident that a dental lesion too slight, or at any rate not of a nature to call attention by symptoms to itself, may yet be sufficient to exert such an influence.

Ohio State Medical Society.

The forty-third annual meeting of this society will be held in Columbus, Ohio, June 13, 14 and 15, 1888. The sessions of the society will be held in Wirthwein Hall, the first session beginning at 2 P.M., Wednesday, June 13. A very full and interesting series of papers is on the programme.

NEWS.

—Dr. Frank P. Foster, editor of the *New York Medical Journal*, is said to be lying ill with perityphlitis.

—A Chinese surgeon, named Leon Jack, has recently arrived in New York and established himself in practice.

—The Medical Examining Board of Virginia has examined thirty-three graduates in medicine for license to practice medicine in Virginia. Twenty-six of the applicants passed, and seven were rejected.

—Dr. F. C. Shattuck has been appointed Jackson Professor of Clinical Medicine in Harvard University. Dr. Whittier, who has been Assistant Professor of Clinical Medicine for sixteen years, has resigned.

—Dr. William G. Goddard, who died in Boston, May 2 , was the oldest living graduate of Harvard College, the only survivor of his class, and the oldest graduate of the Medical School. He was born in 1796.

—Dr. Curschmann, Director of the Medical Department of the General Hospital, Hamburg, has been appointed to the Professorship of Clinical Medicine at Leipsic, made vacant by the death of Professor E. L. Wagner.

—A recent writer in the *British Medical Journal* declares that excessive tea drinking is the cause of early decay of the teeth, possibly through so altering the normal secretions of the mouth as to permit the development of acids and micro-organisms.

—Dr. William White, for many years the army apothecary at the office of the attending surgeon of the United States Army in Washington, D. C., resigned that office in May, on account of ill health. Dr. White has served twenty-seven years, under six different surgeons-general, and was the only man holding office as army apothecary. He was appointed from Pennsylvania.

—During the four weeks ending Tuesday, May 22, the following cases and deaths from infectious diseases were reported to the Sanitary Bureau of the Health Department of New York City: Typhus, 1 case; typhoid fever, 31 cases and 17 deaths; scarlet fever, 772 cases and 135 deaths; cerebro-spinal meningitis, 20 cases and 21 deaths; measles, 602 cases and 34 deaths; diphtheria, 734 cases and 213 deaths; small-pox, 66 cases and 24 deaths.

HUMOR.

A PHYSICIAN says: "If a child does not thrive on fresh milk, boil it." This is too severe. Why not spank it?—*Sinapore Review.*

A UNITED STATES SENATOR who has been called the silver-tongued orator, recently attacked a political opponent in such a caustic fashion that a correspondent of the *New York Evening Post* suggests that his title be changed to "nitrate-of-silver tongued."

AN EDITOR'S MINORITY.—Editor (to young man)—"Your article, I am sorry to say, is hardly up to our standard."

Young man—"Why, my mother thinks it's clever, my wife thinks it's clever, and I think it's clever—three to one, sir; the balance is in my favor."—*The Epoch.*

NOTHING SERIOUS.—Miss Clara (to Featherly, who is making an evening call)—"Poor little Bobby swallowed a penny to-day, and we've all been so much worried about it."

Featherly (somewhat at a loss for words of encouragement)—"Oh, I—er—wouldn't worry, Miss Clara; a penny is not much."—*Harper's Bazar.*

A MIND READER.—The waiter expostulates with a guest for summoning him by a snapping of the fingers, with the remark:

"Are you calling for the dog, sir?"

"Goodness!" exclaimed the guest, "are you a mind reader?"

"Why do you ask?" inquired the waiter.

"Why," returned the guest, "I was about to ask for the sausage."

A LITTLE BUFFALO GIRL was not feeling well, and her parents suggested that she might be about to have chicken-pox, then prevalent. She went to bed laughing at the idea, but early next morning went into her parents' room, looking very serious, and said: "Yes, it is chicken-pox, papa. I found a fedder in the bed."—*Christian Leader.*

A THREE-YEAR-OLD PHILADELPHIAN had heard her parents discuss hygiene until her infant mind was soaked with the subject. One day her dear old grandmother said—meaning to give Bessie a piece of cake—"Bessie, what do you always have after your bath?" The child regarded her grandmother for a moment with inquiring eyes, and then replied: "Reaction."—*Christian Intelligencer.*

IT SEEMS IT IS VERY IMPROPER to question a physician as to the special ailments of one of his patients. On the ordinary grounds of courtesy such a question is impolite, but one can imagine circumstances under which it is pardonable. Somebody who was not informed ventured to ask a Winchester doctor not long since what was the matter with a friend who was under his care. "Matter?" grunted the disciple of Æsculapius. "Matter? Why, she's sick."

LITTLE WILLIE HAD HAD THE SUBJECT of a new brother or sister mentioned to him as a probability in the near future. One morning the nurse called him and said: "Willie, here is a little sister the angels brought you last night." "Oh! let me see!" cried Willie in glee; "the angels never had any parasols, did they?" "Why, what a question. Why do you say so?" "'Cause they let her get sunburnt. She is right red. Take care, let me by, quick." "Where are you going?" "Going to tell mamma. She don't know yet."—*The Colonel.*

OBITUARIES.

EDWARD S. DUNSTER, M.D.

Dr. Edward S. Dunster, A.M., M.D., Professor of Obstetrics and Diseases of Women and Children and Clinical Gynæcology in the University of Michigan, died May 3, 1888, at Ann Arbor. Professor Dunster was a lineal descendant of Henry Dunster, the first President of Harvard, and was born at Springvale, Me., in 1834. He took the degree of M. A. at Harvard in 1856; M.D. at the University of the City of New York in 1859; was Demonstrator of Anatomy at Dartmouth College from 1859 to 1860; Surgeon in the United States army from 1861 to 1866; Professor of Obstetrics and Diseases of women in the University of Vermont from 1868 to 1874; editor of the New York *Medical Journal* 1866 to 1871. Since 1874 he had held a Professorship in the University of Michigan. He was also the author of several medical works.

CHAUNCEY L. MITCHELL, M.D.

Dr. C. L. Mitchell, an old and well-known physician of Brooklyn, died in that city May 8. He was born in New Canaan, Conn., November 10, 1813. After graduation from Union College, Schenectady, he studied in the Medical Department of the University of the City of New York, from which he was graduated in 1836. He was a member of the New York County Medical Society, the New York Academy of Medicine, the American Medical Association, and the Kings County Medical Society, of which he was thrice chosen President. He was consulting physician to the Long Island College Hospital, St. John's Hospital, and the Home for Aged and Infirm Men.

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Clinical Lecture.

OSTITIS OF KNEE; TREATMENT OF ABSCESSES; KNOCK-KNEE; DISLOCATION OF BOTH TIBIÆ.

BY VIRGIL P. GIBNEY, M. D.,
PROFESSOR OF ORTHOPŒDIC SURGERY IN THE NEW YORK POLYCLINIC.

Treatment of Tubercular Ostitis of the Knee.

Gentlemen:—My remarks to-day will be divided into about three equal parts. I shall first speak of the treatment of chronic disease of the knee-joint, what is commonly called white swelling, and which of late years has come to be recognized as tubercular ostitis of the knee, whether it be of a deforming or non-deforming kind. As a rule, ostitis of the knee-joint, that is, inflammation of the bones entering into the formation of the joint, is attended with deformity. A deformity of the knee is very easily recognized, consisting usually of flexion which is frequently combined with subluxation and outward rotation. Fortunately, the most common deformity is flexion.

The mode of correcting flexion of the knee which I shall recommend to you as the best for adoption can be readily demonstrated, and its superiority be easily proven. I may say in this connection that the management of deformities at the knee in children, as practiced by surgeons in this city has varied very much, and the methods adopted have been complex. There have been innumerable splints invented for the correction of the deformity, but I have found that they are generally unsatisfactory. At least surgeons, other than the inventors of these apparatuses, and who are familiar with their use, tell me that such splints are commonly complicated and unsatisfactory; that they do not give the results which the inventors claim for them. I do not hesitate to say that the question of the proper treatment or correction of deformity of the knee in children has not yet been fully settled. The method which I am now employing I regard as the best one known to many of the profession, because of its simplicity and efficacy. There is nothing in the whole range of joint surgery which has pleased me more than this simple contrivance. Heretofore a knee-joint deformity has been a source of great trouble to me; I have taken hold of it with much misgiving. I have adopted several forms of splint for individual cases, but after trying them awhile I would discard them and try others. I would also give ether, divide the hamstrings, put the leg into good position, apply a plaster-of-Paris dressing; but you will find that this method to one who has many cases to treat proves unsatisfactory in the end. I still have half a dozen patients coming to this clinic who have undergone this method of treatment; they have been etherized on various occasions. The limb has been brought into quite, or nearly a straight line, and locked in a hard plaster-of-Paris cast. They have then been sent home with the leg in good position, but they would come back again with an excoriation which compelled me to leave the splint off for a time, a substitute being applied; but the next time they returned the deformity would be found to have recurred. I have gone through with that experience many times the past five years, and it now pleases me very much to be able to say to the parents of such children that there is a method whereby this deformity can be corrected with much certainty.

The method may be described as follows: Two fan-shaped pieces of tin or steel, each

applied to an iron bar, are connected at the smaller expansion by a joint. One fan-shaped piece fits the outer surface of the thigh, the other the outer surface of the leg, the joint being at the knee; a similar instrument being applied to the inner side. The whole is of very simple construction, and can be made by yourself or by any smith. The leg is then covered by a skin-fitting stocking or flannel bandage, some turns are made around the limb with the plaster-of-Paris bandage, then this instrument is applied and covered with the plaster-of-Paris. The lower part of the patella, bordering on the ligamentum patellæ, should be left exposed, not covered by the plaster. The bandage should be applied very thickly in the popliteal space. The limb should be put up in the position you find it, without any extension being made. While the cast on the leg is still damp, take your knife and make a transverse section of it down to the skin through the popliteal space. This completes the first dressing. The patient should now be allowed to go home, and the cast to become completely hardened before you do anything further. After twenty-four hours, and from day to day, if necessary, from week to week you can proceed to straighten the limb with manual force by degrees, maintaining what you gain at each visit by inserting a piece of cork between the divided portions of the plaster cast in the popliteal space. A piece of adhesive plaster passing over the cork to the cast on either side will retain it in position.

I have a patient now undergoing this form of treatment—a woman about twenty-five years of age, who has had deformity of the knee ten or fifteen years. The leg was fixed by fibrous ankylosis at an angle of 135°. She was walking with a decided limp, sometimes supporting the body with the hand on the thigh. When I saw her she was wearing a brace, which gave a slight amount of support, but it did nothing toward straightening the limb. I applied this splint five or six weeks ago. There was considerable tenderness when the first extension was made. I desisted for a week, let the joint alone, had her lie down a good part of the day, and kept the limb at rest. At the end of a week, I straightened the limb a little more. Although I have had to allow a week's interval each time, the limb is now straightened to an angle of 160°. Ordinarily in children the stretching and straightening process can be repeated each day, so that usually you can within a week overcome the deformity and produce very little pain.

Next you will want to know what to do with the limb after having corrected the deformity. Almost any person can correct the deformity, but very few know how to prevent it from relapsing. After straightening the knee completely, you should take off this splint and apply a solid plaster-of-Paris bandage with the limb in the best position which you are able to secure. You should get the limb entirely straightened before removing the first apparatus. After applying the solid plaster-of-Paris bandage you can use a splint known as Thomas's, invented by Hugh Owen Thomas, of Liverpool. It differs from others in that it does rely on adhesive plaster for extension and counter-extension. Most instruments for this purpose are attached to the thigh through adhesive plaster and by means of traction. It is claimed they extend the leg and keep the joint at rest. But a little thought will convince one of the insecurity of this method, for the muscles move upon the thigh, and the skin upon the muscles, so that an enormous amount of traction will have to be made upon the skin to protect the knee against traumatism. Thomas's splint relies for counter-traction upon a perineal ring. The perineal ring at the top and a ring at the bottom are connected by two iron bars, which taper from above, and extend three or four inches below the sole of the foot when the leg is straight. The difference in length between this instrument and the deformed limb is added to the shoe of the sound limb. The child then walks practically on a pair of stilts, but on the affected side the weight is thrown upon the stilt through the perineal ring, and the limb swings down between the two bars. If you do not wish to use plaster-of-Paris in keeping the knee straight, you can obtain this object by a roller bandage. This instrument gives rest to the knee and protects it against traumatism, and the weight of the limb swinging between the iron bars is sufficient to overcome the reflex spasm, which is an annoying symptom of the disease. You will find that under this treatment the infiltration about the joint will subside, that after awhile you will be able to move the patella over a greater area, and that if you attempt to move the limb you can obtain a small amount of motion. But it is best at first not to attempt passive motion. Leave that to nature and the child's volition, and you will sometimes see results which are marvellous. That is, in watching a knee of this kind pass through its different stages, with or without abscess, you will be surprised to see it come out straight, with a small range of motion, which

will increase as time goes on. Of course it is sometimes very embarrassing to a young woman to go on a crutch of this kind, but that does not militate against its usefulness and the necessity of employing it if you want good results.

The first instrument described to-day, employed in straightening the limb, I call Billroth's splint, for the reason that in Glasgow in the Summer of 1887, where I first saw the splint used, Dr. Cameron told me he had recently seen an assistant of Billroth, who said that at the clinic in Vienna they were in the habit of straightening knees by means of this appliance. Having never seen it employed elsewhere, Dr. Cameron and I called it Billroth's splint.

Its use is illustrated in the case of the patient before you, a little girl four and a half years of age, who, according to her mother's account, first complained of her knee about eight months ago. The mother knows of no special cause for the trouble, but thinks it may have been due to a blow with a slate. Noticing that the child walked lame, she inquired and learned that it complained of soreness in the knee. She first noticed contraction or deformity in the knee five weeks before coming to my clinic. About four weeks ago we applied the Billroth splint, and the limb, as you see, is now straight. We will leave the Billroth splint on the limb another week, when it will be removed and the Thomas splint substituted. The latter instrument will be worn at least eighteen months, as it is desirable during that length of time to relieve the joint of all jar and prevent recontraction. While wearing the Thomas splint she will run about and play as she may like.

To illustrate the inefficacy of some other methods of treatment, I present you a boy, seven years of age, a resident of New Jersey, who had been lame three years last January. He came here with a deformed knee, and he has deformity of the knee to-day. The popliteal space is covered with cicatrices left by abscesses, some of which have not yet closed. The limb is atrophied, and forms an angle at the knee of about 135°. The patient has been etherized a number of times and the limb stretched until it had become pretty straight, but something would then occur to interfere with the treatment and to conspire against his recovery. He has been wearing a Thomas splint. I shall now apply a Billroth splint, protecting as well as it may be done the sinuses in the popliteal space, and I doubt not that within ten days the limb will be made straight. I will give as much time as ten days, because there will probably be more pain than usual, necessitating a slower stretching process. I am asked whether I would apply the Billroth splint in a case in which there is free suppuration. I would, but I would leave an opening in the dressing through which I could secure free drainage, and I would leave the limb in a solid plaster-of-Paris dressing until the acute process had subsided, and then begin extension. You can, at whatever stage you begin the treatment, succeed in straightening the limb, except in bony ankylosis.

On Operative and Non-Operative Interference with Abscesses.

The little boy now before you, five years old, has been under treatment for hip-disease about a year and a half. He is now wearing a simple stem splint. The limbs are very nearly parallel; there is some atrophy, but there is very little deformity. Very little flexion is allowed, but the limb can be readily abducted.

A fact of some interest in the case is the presence on the outer aspect of the thigh of an open sinus which discharges pus. This was not present when the boy last visited our clinic. The mother says a "big lump" formed on the outer aspect of the thigh, which "bursted" and discharged "yellowish water." This is a typical instance of the way in which these abscesses sometimes come and go. Here it has not been interfered with at all; while the patient was playing in the street the abscess broke, and nothing was done except that the mother put a piece of cloth about the limb. But the boy shows no constitutional disturbance. On the other hand, there is another boy, of about the same age, and having a similar condition, who some days ago had an abscess on the thigh, which we opened under strict antiseptic precautions, thoroughly emptied the sac, washed it out with corrosive sublimate solution, 1–3000, applied iodoformized gauze and a solid plaster-of-Paris dressing. Yet the father has brought the boy back to-day because of constitutional disturbance. He has a pulse of 120 and a temperature of 101° F.

Orthopœdists often see cases like this, the first named. They put a splint on to protect the joint and keep the limb in good position; send the child out of doors to play; abscesses come and they pay no attention to them, but let them break when they will. The only inconvenience is that the child's clothing is soiled a little. The mother puts a "cloth about the sore," and the child continues running about on the splint. Its health

suffers very little. Finally the sac closes down and there remains only a small sinus or fistulous tract which may continue indefinitely. All the time the child's health continues and it seems to do remarkably well.

There are many cases giving such a history, and to surgeons who claim that wherever pus is found it should be evacuated at once, the orthopœdist replies that in these cases the pus does not cause any trouble whatever; that if the joint is protected, as a rule, good results will be obtained. But it is very difficult to convince anybody who holds the views surgeons generally do about the necessity of interfering promptly with everything surgical. But we can only let them go on believing as they will, while we go on getting good results by our method of treatment. In saying "we," I speak as an orthopœdic surgeon with a leaning toward meddlesome surgery when not against my strong convictions. I know that these abscesses will, if let alone, and the *hip is not protected*, do badly. They go on to produce septic poisoning and to cause irritation about the muscles; sometimes they produce a foul, disagreeable condition, and the child wastes, and dies from sheer exhaustion or amyloid degeneration. But it is an exception to find such a condition of things when you do all that may be done to protect the joint against reflex spasm, to prevent the bones from grating one against the other, to preserve the general health, yet leave abscesses to pursue their own course. Holding this view, I shall not touch the abscess in the boy presented, not even to wash it out. We will give him the benefit of a little wholesome neglect, and simply instruct the mother to grease the parts now and then with some vaseline, and to apply oakum to protect the clothing from the discharges.

A second abscess, small in size, is forming over the anterior superior spinous process of of the ilium, but in view of the fact that the other has done so well, and his general condition has not suffered from it, we will allow this one also to pursue its course, and not evacuate it in spite of the strong temptation to do so.

Congenital Knock-knee.

In this little girl we see what lately was an extreme case of congenital knock-knee, referred to me some weeks ago by Dr. Yale. There was lateral displacement of the patella with knock-knee, and there was also an extreme degree of valgus of both feet. The child had been wearing a knock-knee brace for about two years without any noticeable result. Dr. Yale agreed with me that the proper treatment was osteotomy. The usual supra-condyloid operation was undertaken first on the right limb. When I divided the femur, the patella slipped into place, but I thought there was going to be overlapping of the fragments. This, however, was avoided by traction; a bandage was put on, covered by a plaster-of-Paris dressing, and at the close of the operation the child was taken home in a carriage. No unfavorable symptoms followed, and six weeks later the operation was undertaken on the other limb. Following this operation, however, some swelling of the foot took place, and the patient was in much agony, so that it became necessary to remove the bandage. The bandage had been applied too tightly. She then went on without further symptoms. You now see that her limbs are about parallel; she has no knock-knee. She can bend her knee pretty well. There has been good union between the fragments. She wears a simple knock-knee spring at present to prevent any recurrence of the deformity. Before the operation the malleoli must have been separated a distance of a foot in the standing posture. The incision was made half an inch above the patella and half an inch in front of the tendon of the adductor muscle. Lay your finger across the leg at the upper border of the patella, and along its upper margin draw a line with a lead pencil. Then place your finger on the inner side of and parallel with the adductor tendon, draw a line along its upper margin, and at the point where these two lines intersect make the incision down upon the bone. Leave the scalpel in as a guide to the osteotome. Place a sandbag beneath the knee as a support when using the mallet. Having partially divided the bone you will fracture it by manual force. If you think it necessary you can afterward put in a suture, apply iodoformized gauze over the wound and dress with plaster-of-Paris.

I shall not allow this girl to stand on her limbs for some weeks, for she is frail, and we should run no risk of having the bones broken. Her limbs will be kept straight by this apparatus. The deformity of the foot, which is well marked on one side, will be corrected by a properly constructed shoe, throwing the weight of the body on the outside of the foot, and thus develop the arch.

The question is asked whether it is not better to operate on the outer side than on the inner side of the thigh. That subject has been much discussed, especially in England; and Macewen, of Glasgow, who

has operated thousands of times, gives preference to the operation on the inner side.

Congenital Forward Dislocation of the Upper Ends of Both Tibiæ.

This child, now five months old, was brought to the clinic when three weeks old, when we found extreme hyperextension of the leg, the articular surfaces of the tibia resting where the patella should rest, on the femur, and the articular end of the femur being felt distinctly in the popliteal space. I gave her a little chloroform, and it required about all my strength to place the limb in the normal position. But there are so many creases in the infantile thigh that I did not dare at that early period to put on a plaster splint. I therefore simply flexed the limb and let it return again to its former position. Dr. Ripley saw the child, and did the same thing under chloroform about a week later. Afterward I again reduced the luxation and applied a bandage, which, however, caused some excoriations. When the infant had attained the fourth month I applied a plaster splint, and the limbs are now in very good shape.

Toward the close of his clinic Dr. Gibney presented a number of patients, among others, a young woman who showed the benefits of systematic exercise in lateral curvature of the spine.

—A most heartrending story has been going the round of the German lay press. A goose was bitten by a mad-dog, and shortly afterwards it was killed and eaten by a peasant and his family, the family consisting, in addition to the man, of wife, son, daughter, and maid-servant. In due time symptoms of madness showed themselves in one member of the family after another. First of all the father was attacked, and died in the greatest agony; next followed the daughter; and after her the son was seized with the most frightful spasms, and all the other symptoms of canine madness; then came the wife and maid-servant. Naturally such a dreadful calamity caused the greatest excitement and the deepest commiseration in the whole of the surrounding district. Three doctors from Kolin and a professor from Prague were assiduous in their attentions, but all was in vain. So far the newspaper story. The actual facts (our German correspondent informs us) were these: A peasant's son died of Bright's disease as the post-mortem showed, and a daughter became insane and was removed to an asylum at Kolin. There was no mad-dog, no goose, and all the other members of the family continued in their usual health.—*Medical Press and Circular*, April 11, 1888.

Communications.

Report of Four Cases of Trephining the Skull.[1]

BY H. O. WALKER, M.D.,

PROFESSOR OF ORTHOPŒDIC SURGERY, GENITO-URINARY DISEASES, AND CLINICAL SURGERY IN THE DETROIT COLLEGE OF MEDICINE, DETROIT, MICHIGAN.

Trephining for Intra-cranial Hæmatoma, with Hemiplegia; Recovery.

Case I.—Joe S., Pole, aged 35 years, was brought to St. Mary's Hospital, February 11, 1887, by the patrol wagon, having been picked up the night previous by the police and put in the station, being registered as a common drunkard. I did not see him until the next day, when the house surgeon reported the case to me. Since his entrance to the hospital he had slept most of the time, and it was with some difficulty that he could be aroused. The only information that we could get from him was that he had pain in the left shoulder. We were completely in the dark as to his history. A careful examination of his entire body failed to give us any evidence of the slightest injury. There was paralysis, not complete, of the left arm and leg, with incontinence of urine, pulse 40, respiration 12, and temperature 98° in the axilla. The pupils responded to light. When aroused, he swallowed whatever liquid was given him. I directed full doses of bromide of potassium and a copious enema.

February 13. His condition remained unchanged; the bowels had not moved.

February 14. Condition the same, with the exception that the paralysis was becoming more complete and it was more difficult to rouse him. I ordered drop doses of ol. tiglii until an action of bowels occurred. Three drops were given without avail.

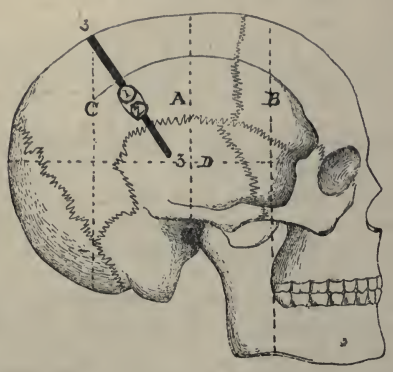
February 15. No improvement. My colleagues, Drs. T. A. McGran and H. T. Lyster, agreed with me that my patient was suffering from compression of the brain, evidently due to a blood clot, and agreed with me as to the importance of trephining. I directed the head to be thoroughly shaved, and washed with mercuric bichloride (1 to 500) and afterwards encased in a cap of several thicknesses of bichloride gauze, to be left on until the next day, the time designated for the operation.

February 16. In the presence of the class of the Detroit College of Medicine I operated. Before operating, however, I mapped out the head with aniline ink, first drawing

[1] Read, and patients exhibited, before the Detroit Medical and Library Association, April 16, 1888.

A, (Fig. 1) auriculo-bregmatic line, and at right angles with this line, D, the fronto-

FIG. 1.



lambdoidal line; then measuring posteriorly two inches and drawing another line parallel with A would give a space in which is found the fissure of Rolando 3–3. Our patient at this time was in a deep stupor, no stertor, complete paralysis of left arm and leg, pulse 38, and temperature normal. The pupils responded feebly to light. The point determined upon for trephining was midway over the right fissure of Rolando, the supposed motor area of the arm, 3–3; after producing anæsthesia with chloroform, a free crucial incision was made through the scalp and similarly through the periosteum, reflecting it back from the skull. On removing the first button of bone (2) a dark mass of coagulated blood protruded through the opening, and in order to facilitate the better removal of coagula I removed another button (1) and chiseled away the projecting bone on each side, thereby making a good-sized oval opening, which enabled me to readily introduce a lithotomy scoop, with which I took away four ounces of coagulated blood. The cavity was thoroughly irrigated with bichloride (1 to 1000) and packed with a continuous strip of iodoform gauze, leaving a piece of it projecting (for drainage) from the most dependent portion of the wound, which I closed with a continuous catgut suture, covering the whole head with a thick bichloride gauze cap. Before the patient was taken from the operating table there was manifest return of motion in the arm.

February 17. Passed a comfortable night; pulse 80, temperature normal, with increased motion of arm and leg; could answer questions fairly well. The dressing was renewed, as there had been considerable oozing during the night.

February 18. There has been gradual improvement since yesterday, without rise of temperature. He informs me that on the day that he was taken to the police station, he and some other fellow-workmen jumped from a scaffold which was giving away, a distance of about ten feet. This occurred at 2 P. M. He continued to work until 5 P. M. without inconvenience. While going home he observed that he could not hold his dinner-pail in the left hand, and shortly after this had no further recollection of anything until the morning following the operation.

February 19. I found him on entering the ward sitting on the edge of his bed; motion in the leg was increased, and his grip of the left hand upon mine was quite appreciable. Incontinence of urine had entirely disappeared. The dressing and iodoform gauze drain were removed, and the latter was replaced with several strands of catgut.

February 24. Patient walks about the ward; renewed the dressing, as there was still a slight oozing.

He continued to improve, and left the hospital March 15, 1887, with the wound entirely healed, and function of arm and leg fully restored, I have seen him several times since, and he is now as well as ever.

Trephining for Extensive Fracture and Depression; Hemiplegia; Aphasia; Recovery.

Case II.—Ambrose McNamara, aged 11 years, entered St. Mary's Hospital, Feb. 18, 1888, with the following history: On the afternoon of February 16; he fell from a building, a distance of twenty feet, striking upon his head. He was unconscious for about half an hour; during the night he vomited frequently small quantities of blood.

February 17. Was delirious at times, complaining of severe pain in his head, and during the night he lost the power of speech.

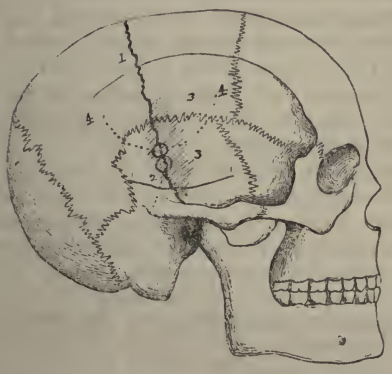
February 18. His symptoms growing worse, his physician, Dr. J. F. Encke, directed that he be sent to the hospital, where I first saw him. At this time there was hemispasm of the left arm, and turning of the eyes to the left. He would start suddenly when spoken to, and attempt to get out of bed. He had full control of his bladder, but had had no movement from the bowels since the accident. One drop of croton oil, however, acted quickly, producing free catharsis. The pulse was 80, and temperature 100.5°; pupils contracted, but responded to light. The entire scalp was greatly swollen,

and pitted on pressure. The point of greatest sensibility seemed to be just above the right ear, yet it was impossible to detect either fracture or depression of the skull. The head was shaved, washed and an antiseptic cap applied, together with an ice bag.

February 19. Passed a restless night, although full doses of bromide of potassium and chloral hydrate had been given. Hemispasm with hemiplegia of left arm and leg was now complete; pulse, 90; temperature, 102°; vision incomplete, and complete aphasia.

At 4 P.M., assisted by Drs. J. F. Encke, W. E. Clark and several medical students, I made a curved incision, with concavity towards parietal eminence, as indicated in Fig. 2 by dotted line (4–4). I found, how-

FIG. 2.



ever, that to expose the depression (3–3) and extent of fracture, it was necessary to extend my incision downwards (5). Reflecting back the periosteum, it was discovered that the fracture extended vertically from just above the external meatus to the parietal eminence, and transversely through the whole width of the squamous portion of temporal bone (1–1–1). There was a marked depression (3–3) in front of the vertical fracture. Removing two half buttons (2) with the trephine, and chiseling off the projecting bone, I succeeded with the elevator in lifting up the area of depression. The dura mater was deeply injected, and under it could be seen considerable coagulum. This was removed by cutting through the dura mater and irrigating with mercuric bichloride 1-1000. Hemorrhage was slight, and easily controlled. The wound was closed with continuous catgut suture. Several strands of No. 4 catgut were used as a means of drainage, extending from within the dura mater out, and the whole was covered with a thick bichloride gauze cap.

February 20. Pulse, 80; temperature, 99.8°. Has passed a comfortable night. I renewed the dressing, as there had been considerable oozing.

February 21. During the last twenty-four hours the patient has had two slight convulsions; pulse, 86; temperature, 99.5°. Spasm of the arm disappearing, with evidence of movement in the arm and leg.

February 23. Has been gaining gradually for the last two days; asks for a drink, and constantly (when not asleep) crying for something to eat.

February 27. Is able to sit up in bed; temperature normal. There is a marked improvement in speech and motion of the arm and leg.

March 2. Not so well. Temperature 99.5°. Eats and sleeps well, however. Ordered wound redressed.

March 6. After redressing of wound the temperature fell to normal, and has remained so ever since. He is now able to walk about the ward.

March 9. At the earnest solicitation of parents was allowed to go home. Wound nearly healed. At the present writing, he has been going to school for two weeks, and appears before you in perfect health.

Trephining for Traumatic Epilepsy; No Epileptic Seizures since Operation.

Case III.—T. Byerenski, Pole, aged 32 years; in June of 1887 was struck on the left parietal eminence with the end of a wagon-tongue. The blow caused unconsciousness for upwards of half an hour. He made a good recovery, but in October had a fit lasting for ten minutes. Since that time he has had several attacks—over a dozen in number—the last one on February 14, 1888. These attacks as described by the patient and his friends, were without doubt epileptiform in character. He gave no history of epilepsy previous to the injury, hereditary or otherwise, and was always in good health.

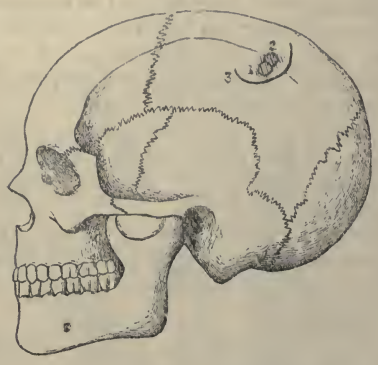
He entered St. Mary's Hospital, February 19, and was prepared for the operation as in the previous cases. At the seat of injury there was a circular depression three-quarters of an inch in diameter and one-fifth of an inch in depth.

February 22, made circular incision as indicated by line (3–3) Fig. 3, and reflected periosteum. First button (1) removed was directly over the centre of the depression; finding that there still existed above a portion of depressed bone, I removed a three-quarter inch disk of bone. The wound was drained and dressed as in the preceding case.

February 23. Dressing removed on account of oozing. Temperature normal.

The case progressed favorably, and the patient was discharged from the hospital, March

Fig. 3.

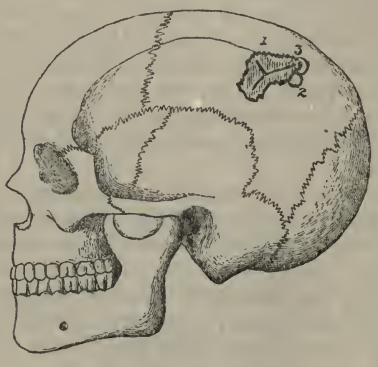


16, with the wound entirely healed. He is now back at his former work, and has not had the slightest symptoms of a convulsion since the operation.

Trephining for Compound and Depressed Fractures of Skull; Recovery.

Case IV.—J. Shemanski, aged 17, March 31, 1888, while attempting to steal a ride on a freight train, was thrown, and struck upon his head, rendering him insensible. He was picked up and taken to his home near by, when in about half an hour he recovered consciousness. His physician, Dr. L. H. Johnson, on being called, summoned me, and I saw him about two hours after the accident. There was a circular-shaped scalp wound about three and a half inches in length, just above the left parietal eminence. Laying back the flap I discovered an irregular-shaped fracture two inches in length, and depressed fully half an inch (1, Fig. 4), so that I could easily put the ball of my thumb in the depression.

Fig. 4.



He had fully recovered from the concussion. Neither he nor his friends seemed to realize the seriousness of the case, and it was with considerable difficulty that I could get them to consent to operative interference. The head was shaved and prepared as in the preceding cases. The opening through the scalp was sufficiently large to permit, after first reflecting the periosteum, of the removal of two half-disks (2–3), at the outer border of the depression, and several spicula of bone. With considerable effort the depressed bone was restored by means of the elevator to its normal position. The drainage and dressing was applied as heretofore described.

April 1. Temperature normal, and the dressings, thoroughly stained from the oozing, were removed and re-applied.

April 2. Found him, contrary to orders, sitting up; but without an unpleasant symptom.

April 16. To-day the dressings were all removed, and the wound found entirely healed. In this case there was no manifestation of an untoward symptom after the first dressing.

I forgot to mention that an ice-bag was applied to the head in all these cases for several days, except in the last case. You will observe, by the several buttons of bone which I exhibit to you, that I neglected to replace them. In my next report of this class of cases if I should be so fortunate as to have any, I hope to be able to present the patients with their skulls intact, by the immediate re-implantation of the pieces of bone removed.

The importance of surgical interference in lesions of the brain is conceded by the representative surgeons of the world, and although I can add but little to surgical literature upon this subject, I feel that in presenting these cases I have at least added a mite of evidence confirmatory of the good work that has been done in this direction during the last few years, and in reiterating the thoughts of others incite you to belief in, and further investigation of, this important subject.

Dr. John B. Roberts, of Philadelphia, in an admirable paper [1] upon "Operative Surgery of the Human Brain," divides the lesions of the brain that we have to contend with as follows: "(*a*) Cranial fractures; (*b*) intracranial hemorrhage; (*c*) intracranial suppuration; (*d*) epilepsy following cranial injury; (*e*) insanity following cranial injury; (*f*) cerebral tumor. The cases that I have presented here to-night are illustrative of cranial fractures, simple and compound, with some of the concomitant symptoms—intracranial hemorrhage and epilepsy.

[1] Annals of Surgery, Vol. II, pages 1–110, 214.

In case 1, in which a blood coagulum was removed, there was no history of traumatism until after the operation was performed, and we had to rely entirely upon objective symptoms as to the nature of the lesion, whether it might be hemorrhage, abscess, or tumor, while as to the site of lesion we were guided wholly by our present knowledge of cerebral topography, a partial diagram of which is exhibited in Fig. 1. The result certainly justified the means employed for relief.

Case 2 was also somewhat obscure, although we had the history of a fall, yet it could not be made out whether the symptoms of compression were due to fracture or hemorrhage, or both. Here again, we were largely guided by cerebral localization. I forgot to mention in the report of this case that the patient is left-handed, which will account for the aphasia, as aphasia in left-handed persons is due to the lesions upon right side of the brain.

Trephining for traumatic epilepsy has been robbed of its terrors since the introduction of antiseptic surgery, thereby justifying an operation when any depression of the skull can be traced as the direct cause of this terrible malady, for if relief or a cure is not effected the danger is *nil.*

Case 3, as has already been stated, has had no return of fits, yet the permanency of relief can only be determined by further time.

Case 4 was a typical one of compound fracture of the skull, and although no brain symptoms were present, and he would have probably got well under the strict maintenance of antisepsis, yet I felt justified in doing what was done, thereby preventing what occurred in case 3, although the depression in that case was considerably less than in case 4.

Abscess of the brain has been quite satisfactorily treated in the last few years by incision and drainage, a number of successful cases having been reported during the last year. A noteworthy case of removal of an intracranial tumor by Dr. Weir, and reports of similar cases by Horsley and others, are among the recent achievements of surgical art.

In conclusion, effective operations for the relief of brain lesions require: *First*, A thorough knowledge of cerebral localization, the details of which can be found in an article by Horsley entitled, "A note on the means of topographical diagnosis of focal diseases affecting the so-called motor region of the cerebral cortex." They may also be found in an article by Seguin, in Pepper's "System of Medicine," vol. v, p. 94. *Second*, A thorough knowledge and appreciation of antisepsis, together with efficient drainage.

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BROWN-SÉQUARD ON CEREBRAL LOCALIZATIONS.

BY E. P. HURD, M.D.,
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This article is called forth by the paper of Dr. C. E. Brown-Séquard in the *Forum* for April, 1888:

I am sorry that the eminent neurologist thought it desirable to write such an article in a popular review, for not one non-medical reader in a thousand can understand it, and all that the ordinary reader will be likely to make of it is that there is a tremendous feud and no agreement whatever among physiologists, and that no advance has been made, or is likely to be made in cerebral physiology. Neither of these propositions is true. There is general agreement among authorities on cerebral physiology and there has been progress made.

Dr. Brown-Séquard is an amiable gentleman to whom the medical profession is indebted for many valuable discoveries. He was the first to publish the effects of galvanization of the sympathetic nerve, showing that contraction of the blood-vessels, diminution of blood, and decrease of the vital properties follow. These phenomena are just the reverse of those that succeed section of the sympathetic. He was also one of the first to trace to their origin in the spinal cord, those fibres of the sympathetic going to the blood-vessels of various parts of the head, and is the author of many ingenious and more or less probable explanations as to the influence of the nervous system on nutrition and secretion, and also as to the relationship of the vasomotors to the production of many diseases, as reflex paralyses and epilepsy.

Dr. Brown-Séquard's discoveries respecting the paths of sensory and motor impulses in the spinal cord and mesocephalon, respecting the effects of excitation of the anterior roots of the spinal nerves, the functions of the gray matter of the cord, the conductors of sensory impressions and their decussation in the cord, etc., are now parts of the history of medicine, and have given him a place among the great men of this century. He who demonstrates one scientific truth is a benefactor; to Brown-Séquard we are indebted for many.

But if Brown-Séquard is high authority on certain parts of the nervous system, he has certainly not distinguished himself in cerebral physiology or pathology, and I am not aware of a single great discovery which he has made in these departments of study.

While he has taught us much that is useful respecting cerebral inhibition, if any real progress has been made in the localization of function in the brain it has not been through him, for here he has had but one mission to perform, that of an obstructionist. In fact, eleven years ago he modestly announced his intention to be "to change almost (*sic*) entirely the physiology, normal and pathological, of the encephalon."[1] In his recent article in the *Forum* he affirms that since 1870 he "has been hard at work to show the untenableness of these [localization] views." From this we infer that the discovery and announcement of truth was not so much his object as the defence of views and opinions formed in the earlier and more plastic periods of his life, and to which he meant obstinately to adhere, despite all facts to the contrary. Like the patron of Alceste in Racine's play, that "*ésprit contrariant qu'il a reçu des cieux*" manifests itself in all his late writings: "*Le sentiment d'autrui n'est pas fait pour lui plaire.*"

In 1876 he delivered before the Royal Society of London a lecture "on the appearance of paralysis on the side of a lesion in the brain," in which he controverted the prevalent doctrine—generally admitted to have few exceptions—that a paralysis due to cerebral disease is on the side opposite the lesion. He cites in support of his thesis over three hundred observations, but, as Seguin observes,[2] most of them are old cases, *i.e.*, cases reported before modern cerebral anatomy was understood, and many of them are related by men utterly or relatively unknown. "Furthermore" we quote from Seguin: "any one who has worked much in the post-mortem-rooms will appreciate how easily *right* is wrongly written, where *left* is meant, as a brain is turned over and around for examination. Consequently, we might claim the right to reject as worthless many of these three hundred cases. Suppose, however, that they are accepted as *bonâ fide* examples of palsy on the same side as an encephalic lesion, and that we compare them with the thousands of cases of classical hemiplegia on the side opposite the cerebral lesion, do we obtain a proportion greater than that observed in Flechsig's series of fœtuses, one to sixty? I think not."

Dr. Brown-Séquard formed his views of cerebral physiology at the time when the teachings of Flourens and Magendie were predominant. Flourens, interpreting certain physiological experiments and pathological observations which had to do with the artificial removal or destruction by disease of certain parts of the brain, saw reasons for the conclusion that there was no particular localization of function, that the whole brain was operative in the performance of psychical function (thought and voluntary action), and that, there being no physiological distribution of labor, but all the faculties and functions having their seat in every part, any portion of the cortex cerebri might, up to a certain point, perform the work of the whole. This doctrine, which certainly has had much to give it support, is essentially that held by Longet and Vulpian.[1] Brown-Séquard early modified it somewhat. There are, he believes, psychical (sensory, perceptive, voluntary) centres, but they are widely diffused; thus, for instance, the cerebral direction by which I am writing this sentence does not come from a motor graphic centre, a definite, localized CLE, if I may be permitted to refer to Charcot's diagram in the REPORTER for March 31, page 402, but from ganglion cells scattered all over the hemisphere and connected by association fibres.

Such a view of the cerebral functions is possible, but it is contrary to the whole analogy of nature, and to that specialization of structure and function which characterizes the evolution of all living beings. It is, for instance, much more in harmony with all analogy and with the law of evolution, to believe that an optical impression, for instance, pursues a definite course, a "beaten track," if the expression may be allowed, to form "cluster-localization," whether in the posterior part of the parietal, or in the occipital lobe, or in both, than that it runs along one fibre to a cell in the frontal lobe, along another to a cell a few centimeters further back, along another to a cell in the occipital lobe, and so on. In fact, it is hard to picture to yourself intelligibly Brown-Séquard's scheme, and when once fairly stated it seems hardly to need any other refutation than its own intrinsic absurdity.

Our best living neurologists come under the ban of Dr. Brown-Séquard's papal pronunciamento (see the *Forum*, April, 1888), and are rather contemptuously styled by him "cluster-localizers." Such men as Fritsch and Hitzig, Munk and Ferrier, Nothnagel and Charcot, some of whom are as careful experimenters and as good clinical observers, and have done as much for science as Brown-

[1] Archives de Physiologie, 1877, No. 2, p. 413.
[2] *Medical Record*, 1878, p. 482.

[1] Longet taught that the cortex was "inexcitable," a statement that subsequent researches have completely overthrown.

Séquard, are included in this denomination. I might allude to hosts of authorities both in Europe and in this country, who have accepted the doctrine of cerebral localizations as supported by convincing scientific evidence, and as in fact the only theory which satisfactorily explains the ever accumulating mass of facts. It is not only a theory which "explains facts," but it has proved itself to be a good working theory, and this is one of the best arguments for its validity. The regional surgery of the brain may now almost be said to be based on the modern doctrine of localization. A train of symptoms (Jacksonian epilepsy, monoplegia, etc.), points to a lesion by a spiculum of bone, or a tumor in a motor region of the cortex; the trephine is applied, and the spiculum of bone or tumor removed, with cure of the disease for which the operation was performed. An abscess of the occipital lobe causing hemiopia has been diagnosticated by the symptoms and the abscess opened, with improvement of all the symptoms therefrom resulting. Instances of this kind are legion, and readers of medical journals are sufficiently familiar with them.

To me nothing is more suggestive and full of interest than Prof. Yeo's experiments on monkeys. They show in the clearest manner possible "that after localized or limited lesion by means of the galvanic cautery of the surface of the brain, certain phenomena of paralyses may be predicted to occur, that these phenomena do actually occur, and that after death microscopical examination shows that strands of fibres proceeding from the damaged parts of the cortex may be traced down to the motor or sensory ganglia at the base of the brain, and thence downward through the spinal cord to the muscles paralyzed by the lesion." "No clearer evidence" says the London *Lancet* regarding these facts, "of the localization of function in the cortex of the brain could be desired."[1]

All these, and multitudes of like facts, it is convenient for Brown-Séquard to leave unnoticed, or dismiss with a sneer, for dogmatism and bigotry have taken possession of him. He has a theory which he must uphold at all hazards, a theory which has made scarcely a convert; he has seen certain facts at the autopsy, or in some of his numerous vivisections, which he thinks are contrary to the received views, and he does not seem to have asked himself, before proclaiming results so opposed to thousands of careful observations by quite as competent experimenters as himself, whether or not the observations which he records were so free from all possibility of error, so trustworthy and unimpeachable, as absolutely to settle the question under dispute. In no department of study are mistakes so likely to be made, or is absolute accuracy so desirable as in researches and examinations into the morbid anatomy of the nervous system. Thus, it seems almost certain that much that has been written by Brown-Séquard and others in opposition to Broca's localization of the speech centre is vitiated and rendered inconclusive by defective observation. This was especially true the first five years after the announcement of Broca's discovery, and during the unprecedented storm of opposition with which that announcement was greeted, even Trousseau was caught tripping by Broca himself, who found a spot of softening in a post-mortem specimen which the former had overlooked. In fact, by thousands of observations, the essential importance of the posterior extremity of the third left frontal convolution for the exercise of the function of speech, remains in the language of Nothnagel at the late Congress of Internal Medicine, at Wiesbaden, as also of his co-reporter Naunyn, "unattackable," and this we may regard as settled, despite Brown-Séquard's sneering remark that "a lesion in any part of the cerebrum may cause aphasia." It seems to me that Brown-Séquard's great mistake is in confounding the results of simple inhibition from irritation (which results are generally temporary) with the more formidable and more permanent results of destructive lesion.

But I have already exhausted the space which I intended to devote to this subject. Dr. Brown-Séquard is now regarded by the profession as behind the times, and nothing which he writes makes much impression on medical men generally, who know how observation and judgment may be warped and vitiated by inveterate prejudice. His statements, made with so much magisterial authority, and reading so much like a papal *ex cathedrâ* deliverance, would, if true, demolish all the notions of cerebral physiology which labors of so many painstaking workers during the last two or three decades have built up, for every theory must give way before opposing facts; but are his iconoclastic statements to be trusted? I, for one, hesitate to believe them. When a man tells you that your next-door neighbor, alongside of whom you have lived for fifteen years, is a scoundrel, a thief and a liar, and you have always found him sincere, honest and truthful, you are slow to believe the statement, and you wait for stronger testimony. So, if a great physiologist, with the most imperturable confidence, assures you that all that you have learned about the

[1] London *Lancet*, American edition, 1882, p. 298.

cerebral functions the past fifteen or twenty years is "moonshine"; that the distribution of function in the cerebrum is simply *chaotic;* that the whole is in every part, and every part in the whole, you will demand proof stronger than his word for it, even though he declares that his experiments have overthrown every one of Ferrier's propositions, or though he appeal to observations, many of which were made years ago, unchecked and unverified by experts, and which may have been hasty, superficial and incomplete.

The matter shapes itself in my mind in this way: If A has followed B as a sequence in hundreds and thousands of instances, and when B does not exist, A is absent, I affirm a law of nature that there is a casual connection between the two. If some eminent authority steps up—Brown-Séquard, for instance—and says: "In my experience, and in the observations of so-and-so, there is no such concomitance," I cannot help doubting the accuracy of that experience and those observations. I place my faith and confidence in the uniformity of nature more than in any one man's testimony, and while there may be exceptions to a general law (and I believe that there may be with regard to the speech centre in the cortex, which may in rare instances occupy a different area), yet absolute *contradictions* do not exist in nature, otherwise:

> "This pillared firmament were rottenness,
> And earth's base built on stubble."

DISEASES OF THE SOUTHERN NEGRO.

BY J. WELLINGTON BYERS, M. D.,
CHARLOTTE, NORTH CAROLINA.

One of the most conspicuous and remarkable facts associated with the development of the medical history of this country is the entire absence of anything like a special treatise upon the peculiarities of disease as manifested in the negro race. The eight millions of this people that principally inhabit the Southern States certainly present many racial contrasts which are vastly interesting and important, and are well worthy of more attention than has been heretofore bestowed upon them. It is a well-known observation that certain individuals are occasionally met with who are but slightly vulnerable to the influences of certain diseases—that when attacked they easily get well; while other, though rarer, instances are found in which the exemption is so manifest as to amount to entire immunity. These same observations can be made to apply with equal force and appropriateness to the peculiarities and susceptibilities which are known to characterize certain races: the total escape of some, as was at one time the case with the negro as regards yellow fever, malaria, and tuberculosis; the modification of others in degree, as witnessed in scrofula and consumption among Indians; and lastly, the perversion of the special type, as is seen in the Irish and German nations. The modifying and diversifying influences of race, climate, social condition and environments in general, upon the production, development, and results of disease are obvious. That they certainly have an important agency in controlling morbid phenomena, and do produce great difference in their manifestation, is equally true. To one who has not given special thought to this department of knowledge, the peculiarities that can be enumerated as pertaining to the colored race alone would be calculated to astonish. Anthropologists pretty generally concede that this people, at least in its natural habitat, is about the lowest stratum in all human kind. Naturally, when we come to consider its features in comparison and contrast with such a race as the Anglo-Saxon, we can but expect to find the most marked divergencies.

For the three and a half centuries previous to 1850, there were brought to this country as slaves nearly fourteen millions of Africans. These were representative of one hundred and thirty-seven different tribes, and there now remain living only about five hundred people that composed this original stock. As represented by a historian of their own race,[1] these came from the lowest classes of society, and were composed of the diseased, barbarous and criminal elements. With impartiality the whole mass may now be said to have passed through at least several generations, and their best and worst features to be fully manifest, if not matured. The Southern States now have a population with a ratio of eight whites to five blacks, and the death rate of the former is somewhat less than fifteen per 1,000, and of the latter a little more than eighteen per 1,000. The chief source of mortality in negroes who have passed the period of infancy, is tubercular diseases. The report of the U. S. Army Surgeon-general, for the year 1884, shows that four times as many deaths occur among the blacks, when affected with disease of the respiratory organs, as of the whites. For the whole country, the negro dies annually from consumption at the rate of twenty thousand,

[1] Williams, History of the Negro Race in America.

while the death from the same cause among the whites amounts to only fifty thousand. The proportion of the living in these two races is nearly seven to one, and they die in a ratio of about three to one. The material conditions that form their environment cannot furnish a reasonable basis for the great contrast presented by this announcement; there must be a superiority on the one hand, and an inferiority on the other, that transcends the usual influences that emanate from ordinary physical conditions. Is the negro inferior by nature, and does this inferiority rest upon sound philosophical principles, such as are permanent and unchangeable in the usual tide of affairs? From an experience that has been varied and extensive, I feel quite safe in saying that the colored race of this country is undergoing serious physical deteriorations as compared with the sturdy condition that they possessed previous to the civil war. The present generation is having a conflict with influences so debilitating and destructive of its physical and moral powers that the evidences of their seriousness are everywhere apparent. Any race of people which can, in a space of time that has been allotted it as freemen, double both its mortality and criminal rates—and the negro race has done this—is inevitably doomed to destruction unless there be immediate and radical changes in its methods of life. The mortality reports of six cities which are given at the end of this article will corroborate these assertions, and show them to be unexaggerated in the least.

Thirty years ago consumption in the pure negro was such a rarity as to be almost unseen in the medical experience of a lifetime. Statistics to-day show that deaths from this cause are in a ratio double that of the whites. Pneumonia, diseases of digestion, malaria, and diseases of the nervous system, all show a higher mortality rate in blacks; whereas in the past the exact reverse was usually true. This critical predicament of the physical condition of this race has already been too long disregarded, and the immediate and remote effects of this neglect and violation of the important laws of sanitation and hygiene among them has become so deeply rooted upon their constitutions, that nothing short of their uttermost degradation and ruin seems at all evitable. From a sociological standpoint a people that is naturally callous to all beneficent and moral impulses which tend to elevate its physical, moral and intellectual faculties, is sure to present a proportional amount of depravity. The negro race is still influenced by the relics of its hereditary barbarism. Charms and witchery among the moral classes still persist in an important place, they believing in their power to produce evils and misfortunes. Added to these infirmities, the negro has the degrading vices that naturally arise from circumstances which surround all such grades of civilization as ours.

The weakest members of the social body are always the ones to become contaminated, and sooner or later succumb to the devitalizing forces of intemperance, disease, crime and death. The negro is peculiarly unfortunate; he has not only the inherent frailties of his nature to war against—instincts, passions and appetites; but also those nocuous, seductive, destroying influences that emanate from free institutions in a country of civil liberty.

What has been written would seem to indicate but one issue for this race of people, and that is too palpable to dwell upon. The causes of the shortcomings of the negro and the avenues through which he reaches them are alike plain. Future progress for him means a thorough and immediate change in the purposes, resources, and methods of life. He needs to preserve his physical powers; he needs temperance in all of its forms: frugality, moral courage and a better system of mental training, one more in concert with his capacity, which would fit him for a proper appreciation of his social and physical status. He must withal endeavor to help himself, and establish in his own race those qualities and aptitudes that go to form character, and a being that will be capable of employing and enjoying the exigencies of moral and physical law. He has been a child too long; he needs to be thrown upon his own resources, for no race can progress so long as it is indulged by a parent with the capital resources of the United States Government.

The brief space here allotted will not permit of more than casual mention of some of the most characteristic features associated with diseases in the colored race. The causes of the rapid deterioration that threaten this people are found to lie in its high sensuality and intemperance, which lead to pauperism, crime, and insanity; its total disregard for the laws of sanitation and hygiene, which conduces to miasmatic, diathetic and enthetic diseases. The negro's capacity for race preservation and perpetuation is remarkably low. The average increase for the white race during the three last decades is not much below 40 per cent., while that of the negro has scarcely been twenty-five. Of the entire criminal class of the whole country, the

negro forms nearly twenty-five per cent. From this much it will be seen that there are inequalities greater than skin, brains or wealth, such as are plainly out of the power of any social arrangement to alter. Evolution by force of external environments may yet do much, but not all; there are the internal relations, which are too far removed from influences capable of making any durable, transmissable alterations, which must continue to exist as a barrier to all transitions of one race into the life of another. These are as fixed as the laws of the universe. Miscegenation is taking place at a less rate than ever, and each year sees it growing smaller.

Civilization seems to increase their liability to diseases of the special sense and nervous system. Dr. Andrews, of Buffalo, has recently said that while the negroes increased in the last decade (1870 to 1880) at the rate of 35 per cent., insanity increased among them at the rate of 26 per cent. This proportional increase of insanity far exceeds that in the whites. It is predicted, with reasonable justification, that by the year 1890 the insane among the colored people will be double what they were in 1880.

Delirium tremens rarely occurs among negroes; the reason of this is attributable to their physical inability to stand prolonged debauch, they are soon forced to give up and the system never reaches that point of exhaustion at which delirium sets in. The opium habit is exceptionally rare among them, and suicidal tendencies are very infrequent. Both sexes are fond of, and are addicted to, the use of drink and tobacco. The women are very prolific, twins are common, and the still-born are twice as common as in whites. Parturition is usually easier, though dystocia is frequent; a woman will be confined one day and up at her duties the next. Uterine disease is common, a great many suffer with fibroid growths, prolapse and displacement. The negro child is not black at birth as is popularly thought, but of a brownish copper-color, resembling closely the color of a white child, but it darkens gradually and in a few days is of the usual tint. The children mature faster, get their teeth earlier and decline more quickly than whites. The diseases of dentition are especially fatal in blacks, one-half of their death-rate being due to this cause, which is probably owing to the bad quality of diet, poor attention, and unhealthy surroundings.

Worms in children are common and often fatal. Rickets is a characteristic, nearly all negro babies are bow-legged; this deformity is usually overcome without special attention. Congenital deformities are rarer in this people than in the whites; talipes in any form, spina bifida, cleft palate, epispadias, hypospadias and exstrophy of the bladder are of the most unusual occurrence. The typical negro is below the average height of the white race, he is muscular, but prone to obesity as age advances. His vision as to distance appears to be superior, and he is signally free from the usual order of eye and ear diseases. Tetanus is common, and in most instances fatal; trismus nascentium is more frequent than in whites, and invariably fatal.

The negro is especially free from skin diseases; this is most marked in those incident to dirt; they rarely bathe their bodies and are notorious for their opposition to water. The eruptive fevers are the more fatal in the form of sequelæ; the mortality from measles is high; malaria, which at one time had no terrors for this people, stands high on the death dealing diseases of this race, and the mortality of negroes from this cause is double that of the whites.

The negro's digestion is superior; he is truly omniverous, though gastric disorders are not uncommon, which are doubtless due to an excessive fondness for, and an abuse of, the hydro-carbon foods. They take large quantities of cathartics with impunity; piles are infrequent and fistulæ are common. They are easily affected by the sight of blood, both sexes are subject to and easily faint, are stoical in great pain, and unmindful of death when stricken with fatal disease. They bear anæsthesia well, stand surgical operations better, and bleed freer than whites. Keloid is very common, carcinoma rare, and malignant growths are usually in relation to the skeleton (osteo-sarcoma) as pointed out by Tiffany. Stricture is often met with, nearly always as the result of neglected gonorrhœa; syphilis is common, both the hereditary and acquired forms, and is, as a rule, more amenable to treatment than in the white race. One important question associated with the statements set forth in the mortality tables of this paper, is how far the excessive mortality is due directly to the influence of racial characteristics, that is, to less actual vital capacity to resist disease and death, or to peculiar susceptability to certain forms of disease. We are qualified to state that the observations here presented are sufficient to warrant the assertion that the high rate of mortality of this race is certainly due more to inherent weakness or physical degeneracy than to any special faults in the environment. The data are spread over too wide a scope of territory

to justify a belief in special local defects. The rural death-rate will be found relatively just as excessive as the urban. Therefore we must conclude that this race is undergoing serious physical decay, and one of its racial characteristics is general inferiority as compared with the white race. The statements here presented show the average and ratio of the death-rate for certain cities of the Southern States. The reports of Richmond, Washington and New Orleans show uniformly a higher death-rate for blacks than whites.

REFLEX COUGH FROM PREGNANCY.[1]

BY GEORGE E. SHOEMAKER, M.D.,
PHILADELPHIA.

All of us have seen cases in which, in the early months of pregnancy, the stretching or pinching of nerve fibres in the uterus has been interpreted, through the medulla, in the muscles correlated in vomiting. All of us know of the reflex sensations, of the vasomotor and trophic changes, of the mental phenomena, and the occasional bowel complications of early pregnancy. Instead of these, in the case which is here related, the sensory impulse travelled from the uterine plexus through other sympathetic paths to the cord, to the medullary centre of the pneumogastrics and out along that and other nerves to the apparatus involved in a cough. The case was as follows:

Mrs. X., aged thirty, very muscular, almost an Amazon in physique. General health apparently perfect. She has had two children, three miscarriages, and is now in the seventh month of her sixth pregnancy. It was in 1885 that she was first seen, while bleeding from a miscarriage at two months. She then stated that for several days before the uterus emptied itself, she had been troubled with a cough, without expectoration, coming on whenever she laid on her back. It ceased with the loss of the uterine contents.

Second attack.—Six months later, having been well in the interval, she was again pregnant at two months. No symptoms causing distress now appeared, except a cough, which, for two weeks, had troubled her as soon as she lay down at night, continuing at intervals until she arose, when it ceased almost entirely for the day. No pain, expectoration, or signs of respiratory irritation. A small dose of bromide and chloral, with hyoscyamus, taken in the evening, at once relieved the condition, which, however, returned immediately if the medicine was omitted. The tendency to cough subsided as pregnancy advanced, and the subsequent labor was normal.

A *third attack*, exactly similar, occurred when she again became two months pregnant, in January, 1888. The cough continued for two weeks before she applied for relief, and then was at once removed by the same treatment as before, a sedative given in the evening.

The patient has never had vomiting of pregnancy. Before coming under observation she had had one child and two miscarriages. History of cough with these was uncertain. Examination showed no malposition or flexion of the uterus, and no laceration or erosion. The organ was freely movable, with no lateral tenderness; the ovaries normal. The diagnosis then, in the three successive pregnancies under observation in this patient, has been reflex cough from gestation, without other symptoms.

That large numbers of the symptoms which we daily see are reflex, it is easy to say, but it is by no means as easy to determine the paths of these reflexes; or to see why, in one case, one path should be taken, and in another case another. With the same stimulus to the same group of nerve filaments, the result will be interpreted in vastly different effects. So intricate, too, are the relations of different parts of the nervous system, and so diverse the influences which serve to switch off, as it were, the ongoing nerve impulse in this direction or in that; that in many instances we are obliged simply to record facts, and leave unexplained, because yet unknown, steps which lead to their development.

It will be remembered that the pneumogastric nerve has an extremely wide distribution and connection. That, besides going to the heart, and besides influencing the vasomotor system through the medullary vasomotor centre, it goes to the lungs and larynx, to the pharynx and œsophagus; that it is connected with the external auditory canal, and with the meninges of the brain; that it goes to the stomach and intestines, to the liver and spleen, and, in short, to most of the abdominal viscera. Its connection with fibres of the sympathetic in the abdomen, enables it to receive impulses from organs such as the uterus, with which direct connection has not yet been fully traced. While most cough is well known to be reflex from stimulus to pneumogastric fibres in lungs or larynx, the same result may follow a stimulus applied almost anywhere in the distribution of this nerve.

[1] A paper read before the Philadelphia County Medical Society, May 9, 1888.

The members of the Society need only be reminded of the cough which occasionally comes from putting a speculum in the external auditory canal, and of that which sometimes follows a disordered stomach; while the writer has now in mind a case of persistent cough, which has resisted treatment for years by the best specialists, and which is, in his judgment, probably due to irritation of the meningeal branch of the pneumogastric in the posterior cranial fossa. Why the connection with the vomiting apparatus offers the easiest outgoing motor path from the medulla for the reflex impulses from the pregnant uterus, we do not know. The reflex sensory, trophic, and vasomotor paths in pregnancy seldom, if ever, lead to the stomach. In the case which has been narrated, the easiest path from the medulla led to the respiratory system, probably as the result of idiosyncrasy alone.

PRELIMINARY NOTE ON SULPHONAL AS A HYPNOTIC.

BY J. C. WILSON, M.D.,
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RESIDENT PHYSICIAN TO THE INSANE DEPARTMENT, PHILADELPHIA HOSPITAL.

Upon the appearance of Kast's communication upon sulphonal, *Berliner klin. Wochenschrift*, April 16, 1888, we ordered a quantity of the drug through Mr. F. E. Morgan. It was received May 24th, but the amount, owing to circumstances beyond Mr. Morgan's control, being only 275 grains, was far too small for any extended or satisfactory clinical observations. We therefore decided to test it in a few cases of the severer forms of insomnia and maniacal excitement. This plan was adapted to avoid in the first place, the errors incident to a limited number of observations in cases of mild, and therefore often intermittent insomnia, and in the second place to aid in determining the range of cases in which the effects of the drug may be investigated in the future. The result was, in view of the reports of Kast and Rabbas, (see editorial *Medical News*, May 26, 1888) a disappointment. It has, however, the peculiar value of negative results in general, and is for that reason published. What doses of sulphonal will induce sleep in cases of this kind, or whether or not sulphonal in any dose or in any doses, unattended by the risk of toxic effects, remains to be determined.

Case I.—As a control test to the subsequent investigations, gr. xxv of the above mentioned drug were given to a healthy male adult upon retiring, with no more effect than his accustomed normal, peaceful repose, and with no ill after-effects whatever.

Case II.—P. F., male, 48 years old, native of Ireland, laborer, was first admitted to the Insane Department of the Philadelphia Hospital January 10, 1885. On April 23, of the same year, after the fire, he was transferred to Norristown, where he remained till March 23, 1887. He is a case of terminal dementia, probably of specific origin, and with a history of alcoholism and the opium habit. Patient has marked delusions of a depressive character, and at irregular periods has acute exacerbations, when he becomes very restless, sleepless and noisy, continually crying out and using the most profane language. The spells lasts in varying intensity for days and sometimes for weeks. He has been given nearly every sedative and hypnotic in the domain of medicine, with only partial results.

Doses of hyoscine gr. $\frac{1}{48}$ *per orem* and hypodermically, and repeated every three hours have but little effect. Morphia gr. $\frac{1}{4}$, chloral gr. xxx and potass. bromide gr. 90; and repeating morphia gr. $\frac{1}{6}$, chloral gr. xv and potass. bromide gr. lx, in an hour have only temporary effect. Paraldehyde ʒij repeated every three yours, the same.

The fluid extract Jamaica dogwood in ʒiij doses, repeated every three hours, with about the same results. Each of these drugs and their combinations in the above mentioned doses have only seemed to quiet him partially and for a short time.

On May 25, 1888, he was given, at 3.30 P.M., gr. xxv of sulphonal, with no effect. On the 27th, at 7.30 P. M., he was given gr. lv, with no perceptible result. There were no ill effects following either of these doses.

Case III.—C. F., male, 45 years old, native of Germany, shoemaker, was admitted to the Philadelphia Hospital, Insane Department, on April 18, 1888. He is a case of paretic dementia, and on admission was in a maniacal state, which has somewhat subsided, but is still very restless, both day and night, spending much of the time pacing up and down the room in which he has to be confined, with mufflers and canvas jacket on, to prevent his wanton destructiveness.

At night he is usually very sleepless, restless and talkative, but as a rule receives no sleeping potions. On May 25, he was given gr. xx of sulphonal at 3.30 P.M., with no noticeable effect whatever.

Case IV.—J. F. M., male, 50 years old, native of Germany, laborer, was admitted to the

Insane Department of the Philadelphia Hospital, on May 19, 1888. A case of paretic dementia, not violent or noisy, but with very restless and sleepless nights. He is constantly talking or muttering to himself, and has occasional spells of laughing.

When put to bed on the evening of the 27th, he received gr. xxx, of sulphonal, which was not followed by any more perceptible quiet or sleep than on former nights.

Case V.—Male, 46 years old, in the preataxic stage of tabes dorsalis; business worries; habitual bad sleep; frequent excesses in drink, followed as a rule by great mental and physical depression and prolonged inability to sleep, often extended, despite large doses of chloral, the bromides, hyoscine, etc., for several nights in succession. Morphine hypodermically not well borne. May 25, after two nights of distressing wakefulness, took 15 grains of sulphonal at 6 P.M.; 30 grains at 7 P.M.; 15 grains at midnight, after which he slept quietly for two hours. May 26, took at 11 P.M., 30 grains, and slept continuously eight hours without interruption. May 27, took at 10.30 P.M., 30 grains without effect. This patient suffered from the gastro-hepatic catarrh, which usually follows a prolonged debauch, and took even liquid food with difficulty; much thirst and nausea; occasional vomiting. No aggravation of these symptoms and no effect whatever upon the pulse, respiration or temperature, followed the administration of the sulphonal. The preparation used in these observations was Merck's.

Kast made more than 300 observations in 60 patients with remarkably favorable results. These were chiefly cases of "nervous" insomnia in neurotic persons, or in patients suffering from organic brain disease, old people with poor sleep, the febrile insomnia of acute diseases, heart disease with sleeplessness, resulting from disturbances of the circulation, and in a single instance the remedy was tried in an old man suffering from senile dementia with active delirium. The result in this last case is not given. The dose varied from 1.0 to 3.0 grams (grains xv–xlv).

Rabbas, Assistant-physician in the Insane Asylum at Hamburg, used sulphonal 220 times in 27 patients in like doses, and reports favorable results, although there were some few failures (*Berliner klin. Wochenschrift*, April 23, 1888.) These were cases of mania (7); hysterical dementia (1); melancholia (9); epileptic dementia (1); senile dementia (1); paretic dementia (3); recurrent mania (1); periodical melancholia (4).

These observers regard sulphonal as superior as a hypnotic to chloral, paraldehyde, the bromides, amylene hydrate, opium, and cannabis indica. It is a pure hypnotic, and without disagreeable after-effects.

Baumann, to whose researches in association with Kast the discovery of sulphonal is due, named it diethylsulphondimethylmethane. It is a member of the disulphon group, having the formula $(CH_3)_2{=}C{=}(SO_2C_2H_5)_2$. It crystallizes in large colorless plates, without taste or smell, fusible at 125–127°C., soluble in 18–20 parts boiling water and 100 parts of water at ordinary temperatures. It is also soluble in alcohol and mixtures of alcohol and ether. Given to dogs, it produces motor disorders, at first ataxic, later paretic, followed by deep and prolonged sleep. In waking, the animals were for a time unsteady, but quickly recovered, took food and seemed perfectly well. A small dog, after an excessive dose, died in convulsions.

The dose for an adult is 1–4 grams (gr. xv–lx). It may be given in water or mixed with fluid articles of diet. In these doses sulphonal has no influence on the digestive organs, nor on the respiration, circulation or temperature.

Society Reports.

ILLINOIS STATE MEDICAL SOCIETY.

THIRTY-EIGHTH ANNUAL MEETING, HELD AT ROCK ISLAND, ILLINOIS, MAY 15 AND 16, 1888.

First Day, May 15.

The Society was called to order by the President, Dr. W. O. Ensign, of Rutland.

Prayer was offered by the Rev. W. S. Marquis.

Dr. C. Truesdale, of Rock Island, Chairman of the Local Committee of Arrangements, delivered the address of welcome.

Dr. C. W. Earle, of Chicago, expressed the pleasure it afforded him to speak in behalf of the Society in response to a welcome to the city of Rock Island, which contained some of the most useful, active and able members of the State Medical Society.

Dr. Walter Hay, of Chicago, sent in his resignation as Treasurer of the Society, and the thanks of the Society were tendered to him for his very efficient services as Treasurer.

President's Address.

In his remarks, Dr. Ensign paid a glowing tribute to those who had preceded him in office, and alluded touchingly to the large number of deaths that had occurred during the year among members. He then dealt with the question of reorganization, and the plans and modes of holding the annual meetings. He thought the State meeting, occurring so shortly after that of the American Medical Association, detracted largely from its interest and attendance. The address touched further upon the relations of the State Board of Health to the study and practice of medicine in the State, favoring the limitation of the issue of certificates to practice to those only who could pass a successful examination before the State Board of Examiners. More thoroughness in all the preliminary branches of education was urged and recommended.

Report on Practice of Medicine.

Dr. Frank Billings, of Chicago, Chairman of the Committee on Practice of Medicine, said he was indebted to Dr. John Rauch, Secretary of the Illinois State Board of Health, for reports which indicated a satisfactory condition of the

Public Health for the Year.—Local outbreaks of diphtheria, scarlet fever, measles and typhoid fever have occurred at different places in the State. In no case has an extended epidemic of these diseases occurred. Croupous pneumonia had prevailed to an alarming extent during the winter. In Chicago the mortality has been greater than for several years.

Bergeon's Treatment of Phthisis Pulmonalis.—The treatment of this disease by rectal injections of sulphurreted gas in carbonic acid has received extended notice and discussion during the year. The expectations raised by the remedy have not been realized. The treatment has been thoroughly tested in the United States, and the almost universal opinion seems to be that it exerts no curative influence on the turbercular process, but does exert a palliative influence, diminishing the sputa, relieving the cough, night-sweats, thoracic pain, improving the appetite, and consequently the strength of the patient. These favorable conditions are temporary, however, and the time comes when the injections cease to have a good effect. In one case under Dr. Billings' care, treated with daily injections for more than two months, glycosuria suddenly supervened. The complication disappeared under appropriate detetic treatment and a cessation of the rectal injections.

The treatment is still in vogue in France and Germany, and favorable reports are made. Cornil and Bergeon have recently experimented with the gas on guinea-pigs. Six guinea-pigs were made to breathe the dust of dried tubercular sputa for twenty minutes daily for five days. Of these, three received no treatment, and three received daily rectal injections of the gas. Of the three which received no treatment, two died in ten days of broncho-pneumonia, and one died in fourteen days with phthisical cavities in the lungs. The three which received treatment remained well and playful. Of these, one was killed in four months, the lungs showing a cheesy deposit which contained tubercle bacilli. One was killed at the end of seven months and showed also a cheesy spot in the lung, but a less number of tubercle bacilli. A third was killed at the end of ten months and showed a calcified cheesy deposit without bacilli.

The aniline treatment of phthisis recommended by Dr. Kremianski consists of the internal use of antifebrine, grammes five to one daily, which is decomposed in the body into aniline, and of inhalations of oil of aniline in one of the aromatic oils. Dr. Bertalero reports successful results in eight cases. Dr. Billings has used the treatment in two cases with absolutely no benefit.

Treatment of Diphtheria.—The use of oil of turpentine in diphtheria has received a new impetus recently. Dr. C. Roesse, of Hamburg, has reported its use in sixty cases. Of these, two were one year old, five were two years old, five were three to five years old, ten were six years old, six were seven to nine years old, fifteen were ten to fifteen years old, ten were sixteen to twenty years old, six were twenty to thirty years old, and only one was over thirty years old. Only five died. Of these, two were one year old, were moribund when first seen, and died within a few hours. Two had the disease in a virulent form and lived only thirty-six hours, and the fifth was a poorly nourished boy of fifteen years old, who died in five days. The oil of turpentine was given in teaspoonful doses three times daily. As a corrective Dr. Roesse used spiritus ætheris, minims xvi, to each teaspoonful of turpentine oil. He also gave a tablespoonful of a two per cent. solution of sodium salicylate every two hours, had the patient use a gargle of a one per cent. solution of potassium chlorate, and applied ice-bags. He noted the following results: (1) The fever and frequency of the

pulse diminished rapidly. (2) The subjective difficulties, such as headache and difficulty of swallowing were soon relieved. (3) The duration of the disease was greatly shortened. (4) The local symptoms improved, in most cases as soon as the first dose had taken effect. The turpentine was used cautiously in anæmic and weak patients, and in cases of cardiac troubles. In strong patients the heart's action was carefully noted. The patients were given strong bouillon or beef-tea, port wine, and milk. Ice-water was given for thirst. The turpentine was withheld as soon as the patient was free from fever and the local symptoms had improved. Usually four or five drachms were given during the disease. Dr. Roesse states that he has never observed any signs of turpentine poisoning as a result of this treatment. The oil of turpentine treatment gives promise of a successful future. Most, however, will hesitate to give it in teaspoonful doses for fear of renal complications.

Dr. Billings has had gratifying success on the local symptoms with a solution of corrosive sublimate, one part to 1500 of water, used as a gargle, or with a syringe with a spray-nozzle, as was first suggested to him by Dr. Frank Johnson, of Chicago. The spray from a syringe may be injected with sufficient force against the pharyngeal walls and tonsils to dislodge the membrane and yet not wound or irritate the abraded surfaces.

Saccharine in Diabetes Mellitus.—This valuable addition to our materia medica renders the treatment of diabetes much easier. Dr. C. W. Purdy has given a clear statement of its antiseptic effects and indicated *how* it may be most conveniently used. Dr. Billings had used it in three cases of glycosuria dependent upon duodenal catarrh, and in one of diabetes mellitus. It fulfils the place of sugar as a sweetening agent, and also acts well as an antiseptic in preventing or relieving gaseous distension of the stomach and bowels.

Antipyrine.—Every day seems to add a new and valuable use of this remedy. Prof. Sée first used it hypodermically in a watery solution in all forms of neuralgia, rheumatism, and other painful affections. He advises friction over the injected area to relieve the disagreeable tension. Dr. R. Hirsch reports the use of the hypodermic injection of a fifty per cent. solution in twelve cases of rheumatism with marked success, relieving the pain and shortening the course of the disease. Dr. J. H. Etheridge, of Chicago, reported the hypodermic use of the drug in articular rheumatism. Several injections were made about the inflamed part with decided relief of pain.

Antifebrine.—Dr. Dumieville has used antifebrine as an anodyne in all neuralgias in over eighty cases with invariably good effect. Fifteen grains in twenty-four hours was the average dose. The effect is felt in from fifteen minutes to two hours. Several reports of cases have been made of dangerous collapse, with or without cyanosis, from the use of the drug. One death is reported of a child from antifebrine; the father of the child doubled the dose ordered by the physician, and death occurred from heart failure in twelve hours.

Sulphate of Sparteine.—This remedy has received more extended use during the last year, and many favorable notices of it have been written. Dr. J. Prior reports that it is indicated in all diseases of the heart where digitalis is contraindicated; where a quick effect is desired, and as an adjuvant to digitalis. He gives the remedy in doses of one-half to three grains, two to three times daily, and says the usually advised dose is too small.

In the discussion which followed this report,

Dr. C. Truesdale, of Rock Island, said that his experience and observations in the treatment of diphtheria were, that the main supports depended upon the character of the case he had to treat. One physician reports cases treated so and so with remarkable success; another, who adopts precisely the same course, loses a large percentage of his cases. He had used turpentine, bichloride of mercury, chloride of mercury, etc., and his experience had taught him that the best remedy was the old-fashioned treatment of the tincture of chloride of iron in large doses; and it was indeed remarkable to observe the large doses of that drug young children would tolerate.

Dr. Earle, of Chicago, said the author of the paper alluded to the cause of pneumonia. It had always appeared to him, especially in the treatment of diseases of children, that simply catching cold, or exposure to it, never could account for a very large number of cases reported. It appeared to him that there must be something beyond that—something in the earth or atmosphere to produce pneumonia in a large number of cases. He had come to the conclusion, although he had never conducted any scientific experiments to base such conclusions upon, that atmospheric influences of some indefinite nature played an important part in such cases, and it was on this account

that he always administered quinine in the treatment. He now regarded pneumonia as a very safe disease in a child, and much preferred a case of it to one of bronchitis involving the small tubes. If a child got a fair amount of quinine, and was well supported, it would get along extraordinarily well, and it was rare for him to lose a case that was fairly well nourished. With regard to diphtheria, he agreed with the last speaker that tincture of iron, etc., had given good results. He uses the tincture of iron, and chlorate of potash once in every four hours, but where it is desirable to make a good impression upon the pharynx such a dosage is not frequent enough; and recently he had given that mixture every two hours, and between it minute doses of bichloride. By carrying out this line of treatment his recoveries took place a little earlier than is usually the case.

Dr. J. W. Cowden, of Rock Island, said the treatment of diphtheria had deeply interested him. Jacobi recommends tincture of iron and chlorate of potassium. He, himself, gave it every fifteen minutes in teaspoonful doses—that is, he gave a child two years of age ten drop doses of tincture of iron. It will allay the pharyngeal inflammation and takes the place of a gargle. It was admirable when given in that way. In less frequent doses, or at a greater interval, it was disappointing. Another thing, was to support children by giving them milk in abundance. Children sometimes would also take an enormous amount of alcohol. He had a little child last winter that would take a teaspoonful of warm whiskey every half hour for forty-eight hours and would take nothing else with it.

Dr. Henry J. Reynolds, of Chicago, asked for some further light in regard to the physiological effects of antipyrine. He said it was an extremely powerful drug, and as useful as it was powerful, but thought it capable of doing a great deal of harm, in that in some cases it produced disorder of the kidneys, suppression of the urine, uræmic poisoning, etc.

Dr. T. W. McIlvaine, of Peoria, had used turpentine in the treatment of diphtheria in much larger doses than those mentioned by any of the previous speakers, and had had no toxic effects from the drug or unpleasant effect upon the secretions, especially of the bladder and kidneys. With reference to the use of bichloride of mercury, he had great confidence in it, used both internally and as a spray; he gives it in combination with lactic acid as a spray. The conditions under which antipyrine is administered should be more carefully studied. He had had patients in which it acted admirably under certain conditions, and again in the same patients the same dose had produced very unpleasant symptoms. He had in mind the case of a woman who had taken it several times with almost immediate relief, it being given in 7½ grain doses, repeated in one hour if the first dose was not sufficient. But on another occasion when the drug was made use of it brought on unpleasant symptoms, such as cyanosis, dizziness, trembling, purple lips, purple finger-nails—in short, rather alarming symptoms. Now, why it should so act at one time, and not at another, is a thing that should be carefully noted and studied.

Dr. J. S. Miller, of Peoria, remarked that in the treatment of diphtheria it seemed to him that, as Dr. Truesdale had said, we should adapt our remedies to meet the indications and emergencies of our cases. In anæmic patients, where children are not robust enough to tolerate active medication, the physician should be guarded in the administration of drugs. In the cases that had come under his observation he had demonstrated the efficacy of cold applications to the throat and angles of the jaws. In cases where there was high fever, and a high temperature, he would admit that there was no remedy which had given him as great satisfaction as the application of cold to the throat and neck.

He had had but little experience in the use of antipyrine. He had used it in cases of typhoid fever, and it produced almost fatal collapse. He had recently treated a case of malarial neuralgia with most excellent effect with antipyrine. Hypodermic injections failed to control a recurrence of the neuralgic attack, but a few doses of antipyrine controlled it immediately. That was the only case in which he had used antipyrine with good effect.

Dr. J. W. Morgan, of Port Byron, had used the biniodide of mercury in the treatment of diphtheria with gratifying results. It was far better than corrosive sublimate, from the fact that it was the most diffusible mercurial preparation we have.

Dr. Billings, in closing the discussion, said the paper was not intended to embrace the treatment of diphtheria, phthisis pulmonalis, or anything else, but was simply a *résumé* of the progress made and the new impetus the treatment of diphtheria had received by the use of the oil of turpentine.

Gynecology.

Dr. A. Reeves Jackson, of Chicago, chairman of the committee on gynecology, read a paper entitled:

"Hands Off; A Plea for Conservatism in Gynecology."

He said that during the past quarter of a century, and especially during the past ten years, no department of medicine has shown greater activity or made greater advancement than that which embraces the abdominal and pelvic surgery of woman. Many diseases which formerly baffled the utmost skill of the physician and surgeon, and doomed the patient to a life of pain and misery, or to certain death, are now treated with a highly satisfactory degree of success, and the lives that have been saved and made bearable by modern gynecological methods may be counted by the thousands. When we recall the fact that Sir Spencer Wells has performed 1,500 ovariotomies; that Lawson Tait has opened the abdominal cavity over 2,000 times for various purposes; that many other operators, at home and abroad, number their gynecological operations by hundreds upon hundreds, we cannot but be impressed by the great need for this work, and the incalculable benefit to suffering women that has resulted from it. No words of praise can adequately meet the deserts of these apostles of humanity. But, as an adverse result of the great success which has been achieved in this direction, there has arisen a class of ambitious imitators, who, actuated by more conceit than conscientiousness, more zeal than judgment, are rapidly bringing discredit upon the honest work of others in the estimation of many, who cannot, or, at least, do not distinguish between the real and the sham, the true and the false. These persons are apparently afflicted with an uncontrollable itching for rapidly acquired fame, and seem to think they can achieve what they desire by beginning where their masters left off. With them, gynecology no longer includes adequate effort for the cure of disease, and only signifies the art of cutting something out.

In one instance within his knowledge, when a spectator at an ovariotomy suggested a doubt as to the necessity for the mutilation, the operator audaciously pointed out that the ablated organs were already in a state of incipient cystic degeneration—the proof of the alleged fact consisting in the presence of Graeffian follicles in various stages of development.

When operations involving danger to life, such as laparotomy, are undertaken for the possible relief of vague nervous symptoms, hysteria, epilepsy, not clearly of ovarian origin, for insanity, or because there is nothing else to do, then such operations are improper, and should not be made. When a man is nervous, or irritable or insane, does anyone propose castration as a remedy? Would not such operation, although vastly less dangerous than the extirpation of the ovary, be regarded as malpractice? And when a corresponding operation is glibly proposed for a fretful, weak-backed, weak-minded, nervous woman, would not the opinion as to its necessity be greatly modified if the patient were a near relative—a mother, wife, sister, or daughter? And why? Because it is well-known that such operations are not always, not even frequently necessary, and that they sometimes kill, and do not by any means generally cure. If anyone finds himself in doubt as to the correctness of a conclusion in such cases, or as to his own honesty of purpose, let him take the case home to himself. If this were done there would be a smaller number of uterine appendages removed, a smaller number of hysterectomies performed. But, so long as the reputation of a gynecologist as such, is thought to depend upon the number of laparotomies he has done, rather than the number of patients he has cured and saved from mutilation, so long will the meetings of medical societies be enlivened by the presentation of platefuls of preserved ovaries and tubes.

The word "successful" in many cases in which laparotomy is done, means that the patient was not killed during the operation; that the reports are sometimes made so soon after an operation that the patient has had no time to die unless from shock, ether narcosis, or hemorrhage, and then no report seems necessary.

Once at a meeting of a medical society at which he was present, a fibroid tumor of the uterus was exhibited. The uterus and appendages had been removed by laparotomy a few hours before. He was informed the patient was "doing well." Inasmuch as there did not appear to have been symptoms sufficiently serious to warrant so dangerous an operation, he felt interested in learning the final result, which was that the patient continued to do well until she died six days later. The termination was not reported. An account of the case appeared subsequently in the published transactions of the society with this heading, "Successful Removal of a Fibroid Tumor of the Uterus."

This premature reporting of favorable cases (the others are frequently not reported at all), has the effect of misleading inexperienced persons who may feel tempted to repeat what seems to be so simple and beneficial.

Do you know, gentlemen, to what extent and for what purposes this indiscriminate laparotomy is proposed and performed? Let me cite a case or two that have come under my observation, all within less than a year: About nine months ago a gentlemen carried a woman in his arms into my office, and after placing her upon a lounge, said, abruptly, "Doctor, I want to know whether you can cure my wife without removing her ovaries?" The question was more easily asked than answered. I deferred giving an opinion until I had an opportunity of investigating the case. The woman was 30 years of age; she had been married eleven years, and had two children and one miscarriage, the latter having occurred three years before. She was a well-informed, well-nourished woman, of medium height, and had a wholesome visage. Menstruation was regular and painless; the functions of the bladder and rectum were normally performed, although there was a tendency to constipation; appetite fair usually, but capricious. Physical examination revealed a slightly congested lower segment of the uterus, the cervix being somewhat club shaped, owing to a slight laceration of the os uteri, on the inner side of which was a superficial erosion of no pathological importance. The ovaries and tubes could not be felt, and there was neither swelling nor tenderness in their neighborhood. The woman was fretful, irritable and lazy. She had been under medical treatment for various ailments (which she probably did not have), during the last three or four years, and had been the latter six months under the care of a gynecologist in Chicago, who had used the customary hot douches, glycerine tampons, massage, etc., without perceptible result. When the impatient husband asked whether anything more or anything better could be done, he was told that the only thing that offered relief was the removal of the ovaries. There was no pelvic disease present, and there was no further pelvic treatment. The patient left the city in a few weeks for her home.

About two months ago Dr. Jackson learned that she was pregnant, and still later, that she was doing well and was able and willing to do all kinds of light housework, and to take moderately long walks.

Again, a young woman, 19 years of age, had been suffering occasionally during several years from irritable bladder. She had been treated by a number of physicians with sometimes temporary benefit. Being finally referred to a gynecological semi-specialist, he informed her that inasmuch as so many remedies had failed to cure her, he would advise the removal of the ovaries. She still has them.

In a third case, the patient was 22 years old; menstruation commenced at 12, but had always been scanty and irregular, appearing at intervals of from six weeks to as many months. Her appetite was poor, complexion sallow, and her face affected with acne. She was advised to have her ovaries and tubes removed —with what object she could not imagine, unless it was to transfer them to a bottle or plate. May 1, her physician in reply to a letter wrote Dr. Jackson as follows: "The soft rubber stem was retained for three months, which established her menstruation in much better condition than previous to its introduction— that is as regards the quantity of the flow. I find she is in very good health as compared with what she was last year."

Think of it! Women advised to have important organs removed, the mutilation involving dangerous operations, for the cure of a nervous affection of the bladder, for scanty menstruation dependent upon feeble general health, and for laziness! Does not all this justify a remark recently made by Thomas Keith, that "in abdominal surgery responsibility seems to have become old-fashioned and gone out of date."

Dr. Horatio R. Bigelow, speaking of the dangerous tendency to operative measures, said: "Who can begin to enumerate the number of cases in which the abdomen has been opened for supposed ovarian diseases, when not a trace of anything pathological was discoverable? Who will write the history of the cases in which perfectly healthy ovaries have been removed as an offending cause without the least improvement in the general condition of the patient? A human being mutilated, deprived of her distinctive characteristics, and rendered miserable! A human life poised between earth and heaven to gratify a bad diagnosis, faulty pathology, or the personal conceit of an irresponsible practitioner! A human life sacrificed to ambition upon the operating table! Do you wonder, can you wonder, in the face of the grinning, horrid, damning facts, some of which are on record, and a host of which hide their ghastliness in dark places, that there should go out throughout the land a cry for conservatism?"

The evils to which he had called attention were great. Dr. Jackson feared they were growing worse. A woman has an inalienable right to all the organs with which she has been endowed. She should only be deprived of any of them when it is clear that through disease or faulty function, otherwise incurable, her health is seriously impaired or destroyed, or her life imperilled, and only then when deprivation reasonably promises relief. To those who from selfish, reckless, or other improper motives, would remove from a woman any of her peculiar organs, he would say, in the name of womanhood, in the name of common honesty, in the name of humanity, "hands off."

Dr. J. M. CULLIMORE, of Jacksonville, read a paper on the

Menopause.

The most important and frequent pathological conditions incident to the menopause are first, the premature menopause; second, neuroses; third, hemorrhages. Under the first head he included those cases which, at about the usual age or earlier, the periods which have hitherto been regular cease for a time. The condition usually comes on in direct consequence of physical or mental shock, some general disease, some genital affection, mechanical violence or blows, sudden bereavement, tuberculosis, typhus or typhoid fever, cholera, pyæmia, inflammation of the ovaries, and difficult labors.

Under the second head the uterus, ovaries, Fallopian tubes, the clitoris and labia, the bladder, urethra, rectum and perineum joined in producing both local and reflex nervous disturbances at the period of the climacteric.

The third class includes those hemorrhages due to cancerous degeneration, to softening of the uterine tissues, and particularly of the mucous membrane.

DR. O. B. WILL, of Peoria, in opening the discussion, said that so far as he was personally concerned he could approve every sentiment expressed in Dr. Jackson's able paper. He could not agree with Dr. Cullimore, however, that the menopause or change of life was pathological. It is a physiological change, and as such under circumstances of good general health will terminate favorably in each instance. It is only where other well formed disease conditions are present that we have the disease manifestations. He would treat that class of cases as he would a disease of a similar kind, whether it was at the menopause or not. There is a morbid condition present in such instances that must be reached, and is not dependent upon simply the matter of change of life.

DR. EARLE, of Chicago, said he wanted to say a word or two in commendation of the paper. It was timely and exceedingly appropriate, and he thought it absolutely necessary that some one should read just exactly such a paper as Dr. Jackson's, with the hope of eradicating or removing the craze that had seized a large number of physicians for operating.

DR. C. TRUESDALE, of Rock Island, remarked that he may have misunderstood Dr. Jackson in the beginning of his paper as to whether he commended the work of Lawson Tait and Sir Spencer Wells. If he understood the matter aright, a laparotomy that had for its object the removal of the uterine appendages was an operation which was being greatly abused, and that if there was any man responsible for it, it was Lawson Tait, for he had operated in this way oftener than any other man in the civilized world. He would admit that Tait had been successful in his operations if the reports of percentages of deaths could be relied upon.

DR. JACKSON, in closing the discussion, said that his allusion to the work of Sir Spencer Wells and Mr. Tait was only intended to show that, whether they were always right or wrong, there is a foundation for the great amount of work they had done and are doing, as he considered them honest, and highly commended them in such a line of work; but he had reference more particularly to the fact that perhaps hundreds of lives had been sacrificed through the indiscriminate use of the operation by inexperienced, ambitious imitators, whose desire was to open the abdomen and cut something out.

NEW YORK ACADEMY OF MEDICINE.

SECTION IN PRACTICE OF MEDICINE.

Stated Meeting, May 15, 1888.

R. C. M. PAGE, M. D., in the chair.

The Therapeutic Value of the Saratoga Waters.

DR. T. HERRING BURCHARD, the author of the paper, gave our very limited definite information regarding their therapeutic value as an excuse for calling attention to waters which had for so many years been used by the American public. The danger of partaking of the waters without medical guidance was shown in the fact that he knew of two persons in whom their use in excessive quantity had caused death; while in others it had given rise to gastric, pulmonary, bronchial and renal affections. Rules for their medicinal use were formulated on clinical

observation and on their supposed action, according to the mineral ingredients which they contained.

In all of the twenty-eight or more springs, the water was charged with carbonic acid gas, and usually to a much greater degree than any of the waters of Europe, which rendered it more tasteful. The Congress was mildly cathartic and tonic, while the Hathorn was more strongly cathartic, and for a few days acted very satisfactorily, but if continued it not infrequently caused rectal or renal irritation. The use of the Congress was not followed by subsequent obstinate constipation. The Vichy was less alkaline than the European Vichy, but it contained a larger percentage of carbonic acid gas. On the other hand, the Columbian and the Hamilton Springs contained more iron than those of Europe, there being in each pint of the Columbian Springs 698-1000 of a grain, and in the Hamilton 578-1000 of a grain. Dr. Burchard thought the benefit produced by iron in anæmia, chlorosis, etc., was greater when taken in the spring waters than when administered in the form of a tincture or otherwise. There were two sulphur springs, for which decided advantage was claimed in the treatment of rheumatism and catarrh, although his own experience with them had been negative. After pointing out the general characteristics of the waters, Dr. Burchard considered the probable effect which any given water would have upon any given disease; also the personal peculiarities of the patient; the very important question of exercise and regimen during the taking of the waters, and how the waters could be best given to meet these requirements.

It was best to place the patient on small, regular doses, increasing according to the therapeutic effects observed. The diet, as a rule, should be simple and non-stimulating; the heavy albuminoids should be sparingly used. In cases of chronic dyspepsia there should be the utmost care taken against the occurrence of flatulence and colic. The patient should not exercise to fatigue.

The diseases in which benefit was to be expected were not acute, but chronic, and in his experience were the following: Dyspepsia dependent on gastric or intestinal catarrh; dyspepsia from gastric or intestinal atony or constipation; chronic constipation; hepatic derangement; lithiasis and oxaluria; biliary concretions with a history of hepatic colic; chronic Bright's disease with secondary complications, especially chronic anæmia, gastric catarrh, etc.; general debility and anæmia; rheumatism and gout; and, strange to say, he had seen much benefit in some cases of diabetes.

Dr. Burchard thought that if the use of the waters at Saratoga was under proper guidance many people would be saved the expense and time of going to European springs, which were used under the advice of medical experts. The great variety of the waters at Saratoga would spare patients the trouble of going from one spring to another, which was rendered necessary on the Continent.

The paper elicited some general remarks from Dr. G. B. Fowler, who thought people usually did not drink sufficient fluids, considering that the human body was largely composed of water; from Dr. Doremus, who thought that the effect of many waters now on the market was simply that of pure water or of salt waters impregnated with carbonic acid gas, and was glad to see the medical profession taking cognizance of the advantage of American mineral waters; from Dr. L. D. Bulkley, who had obtained benefit from the sulphur springs of Saratoga, and who thought the reason why patients did not remain permanently benefited after going to the springs was, that on returning to their homes they returned also to their former bad habits. He thought harm might come from the custom here of taking the mineral waters cold, whereas in Europe they are used warm. He had obtained much benefit by administering simple hot water before meals, having patients avoid iced water with meals.

Dr. W. B. Wood then read a paper on

Recent Clinical Results with the Pneumatic Cabinet.

The pneumatic cabinet is the instrument invented by Dr. Williams, of Brooklyn, for the treatment of chest affections, and consisting essentially of a chamber from which the air could be more or less completely exhausted, forming a partial vacuum around the patient's body, while he inhaled air through a tube from without. The inhaled air could be medicated if desired.

Dr. Wood's paper was supplementary to one which he had read within a year, and in it he narrated about eight cases recently treated, and stated that by this method pleuritic adhesions, and in a general way, pleurisy could be positively cured; and that inasmuch as the evidence which he offered in addition to that commonly furnished by autopsies went to show that pleurisy always preceded phthisis, he thought the latter disease could, if taken in time, also be prevented.

The experience of Drs. D. R. Brown, Sidney Fox, Williams and De Watteville,

who had employed the pneumatic cabinet, was confirmatory of that of the reader of the paper. Dr. Williams had always sought to prevent physicians from drawing irrational conclusions regarding the action of the cabinet. He had never asserted that it would cure phthisis. He had impressed its value in warding off the disease, and the improvement which had resulted in developed cases.

Dr. De Jager did not wish to question the clinical results of the advocates of the pneumatic cabinet, but he could not understand wherein its action differed from Waldenberg's apparatus for the inhalation of condensed air, and he would like, inasmuch as the cabinet was too expensive for physicians generally to purchase, to have a committee appointed to report on its mechanical or other action.

Dr. Beverly Robinson gave expression to the same desire, and was decidedly skeptical as to the cure of pleurisy and old pleuritical adhesions in eight or nine days.

Dr. A. S. Hunter had found much benefit from the chest expansion and lung capacity developed by the pneumatic cabinet in women who had been chronic complainers, and had received all sorts of treatment, such as repair of the lacerated cervix and of the perineum, etc., at the hands of various physicians, and whose condition had in no wise thereby been permanently improved.

MEDICAL SOCIETY OF THE STATE OF PENNSYLVANIA.

THIRTY-NINTH ANNUAL SESSION, AT PHILADELPHIA, JUNE 5, 6, 7, 8, 1888.

First Day, Tuesday, June 5.

The Society was called to order by the President, Dr. R. J. Levis, of Philadelphia.

Prayer was then offered by Right Rev. O. W. Whitaker, D. D., Bishop of Eastern Pennsylvania; and this was followed by the presentation of register of delegates by Dr. W. B. Atkinson, Permanent Secretary.

The address of welcome was then delivered by Dr. John H. Packard, Chairman of Committee of Arrangements.

Dr. Packard briefly sketched the origin of the society and its succeeding history, the good it had accomplished and would accomplish, and in the name of the Philadelphia members extended to the visiting doctors a hearty and sincere greeting.

The medical officers of the army and navy of the United States who are resident, or at present in Philadelphia, were invited to take seats as guests of the Society.

Dr. DeWolf, delegate from the Medico-Chirurgical Faculty of Maryland, was presented.

Report of Delegates to the American Medical Association was read by Dr. Anderson. The Treasurer, Dr. O. H. Allis, then read his report.

The report of Dr. Allis, the Treasurer of the Society, showed that during the year there has been $3,974.54 in the treasury, $2,794 of which was the balance from the preceding year. The expenditures were $2,338.16, leaving a balance of $1,636.38. The following auditing committee was appointed: Dr. Pollock, of Pittsburg; Dr. Green, of Easton, and Dr. Willard, of Philadelphia.

The Committee on Publication then reported, through its Chairman, Dr. Wm. H. Parish, that 2,250 copies of the transactions of the Society for 1887 had been distributed at a cost of $764.59. Last year only 2,000 copies were published, and these cost the Society $1,618.88. An interesting feature of the report referred to the financial relations of the County Societies to the State Society. It appears that at the beginning of the year just ended, only 17 out of 50 County Societies had paid their full share of the expenses of the State Society. The committee believes that with careful business management, the annual dues *per capita* can be reduced from $1.50 to $1.00—perhaps, seventy-five cents.

The following amendment to the constitution was adopted:

"That the censors of the appropriate district, or districts, shall have power to determine whether a resident of one county shall be entitled to become a member of an adjacent County Society which may be more convenient for him to attend."

Also, the following amendments to the By-Laws:

"Sec. 5. The Committee on Pharmacy shall consist of five members, to be appointed annually by the President, whose duty it shall be to consider all matters pertaining to Pharmacy, and who shall be empowered to represent this Society in conference with a similar committee to be appointed by the Pennsylvania Pharmaceutical Association. They shall report annually the result of their joint labors."

And a section, not numbered:

"There shall annually be constituted as the first item of business at the afternoon session of the first day, a Nominating Committee to

consist of one member from each county, named by a majority vote of the delegation from that county, who shall report as the first item of business in the afternoon session of the second day a list of candidates for officers and necessary committees."

The Committee on Medical Education made a report through its Chairman, Dr. Jackson, and offered the following resolutions:

Resolved, That a committee of five be appointed by the President to secure the coöperation of county medical societies and individuals interested in the subject to urge upon the State Legislature the enactment of a law essentially identical with that proposed by this society, and favorably reported to the House of Representatives at the last session of the Legislature.

Resolved, That the sum of $100.00, or so much thereof as may be required, is hereby appropriated to meet the expenses of that committee.

Dr. Finley, of Altoona, objected to medical legislation, and quoted instances to show that such legislation had rarely been felicitous in its results. "If the Legislature passes the proposed act," he said, amid laughter, "the Board of Examiners would be composed of charlatans, bummers, ward politicians, homœopaths and other so-called members of the medical profession."

The consideration of the resolutions was postponed until after the reading of two papers on the programme on this subject.

New Committee on Clinical Research.

Dr. J. Madison Taylor, of Philadelphia, proposed that in the place of the present Committee on the Collective Investigation of Disease there be constituted a Committee on Clinical Research, consisting of 15 members, a Chairman, Secretary, Assistant Secretary, Physician, Surgeon, Obstetrician and Pathologist, whose duties shall be to coöperate with observers in placing on record clinical observations for the special purpose of increasing the scope and interest of papers read before the annual meeting of the State Medical Society. It shall act as a medium of intercommunication between members of the State Society for the collection of notes, specimens and the like, as it is hoped by such aggregation to increase and utilize the value of material obtained, and encourage and aid in research those to whom competent libraries are inaccessible.

The resolution was endorsed by Dr. Tyson, chairman of the Committee on Collective Investigation, Dr. Dercum and others, and was adopted.

Management of Hospitals for Insane.

Dr. Hiram Corson presented a preamble reciting the disadvantages of the system under which the Superintendents of the State Hospitals for the Insane at Harrisburg, Warren and Danville are charged with the business management of the hospital, as well as the medical care of the patients, and offered the following resolution:

Resolved, That a committee of seven be appointed by the President of this Society to memorialize the Legislature for such change in the law governing the three hospitals named, as will confer on the Boards of Trustees full and exclusive power of management, and make it incumbent on these Boards to provide that medical chiefs, male and female, and their assistants shall perform such duties only as pertain to their offices as physician to the insane.

A prolonged and animated discussion followed.

Dr. S. S. Shultz, Superintendent of the Hospital at Danville, spoke at length on the opposite side of the question, upholding the plan of having the administration of the institution concentrated under one head, as it is in the three institutions named by Dr. Corson.

Dr. W. T. Bishop, of Harrisburg, opposed the preamble and resolution, and moved that they be returned to Dr. Corson. He said that the superintendents were responsible to the Trustees and to the Governor of the State, and it was therefore useless to charge them with dereliction and then ask the Legislature to change the conduct of affairs.

Dr. E. A. Wood, of Pittsburg, spoke warmly against any such action, which, he said, would be an insult to one who had been a lifelong philanthropist.

Dr. John Curwen, Superintendent of the Hospital at Warren, and Dr. John C. Gerhard, Superintendent of the Hospital at Harrisburg, also opposed the resolution.

Dr. J. Z. Gerhard, of the Harrisburg Hospital, emphatically denied any dereliction of any duty.

Dr. Corson was then given ten minutes to further explain his views. He said that he had no self-interest in the matter, but thought that it was a question of the greatest importance to the people of the State. He said that the idea was to put the Danville, Harrisburg and Warren institutions on the same plan as that at Norristown, which was managed in the way he proposed. He said there was not a better managed institution in the civilized world. A motion to adjourn in the midst of the discussion had been made and lost, and Dr. Seltzer had unsuccessfully moved that the

resolution be laid on the table. When Dr. Corson had ceased speaking the motion was passed and the resolution was tabled.

At the afternoon session, Dr. Traill Green, of Easton, delivered the

Address on Hygiene,

In which he emphasized the importance of proper ventilation, cleansing of the skin, and drainage. It is the duty of physicians, he said, to point out to their patients violations of the laws of health. Dr. Green devoted much attention to the facts of the general absence of great suffering in the hour of death, the almost utter impossibility of such a thing as premature burial, and the common error, one unsupported by facts or science, that the bodies of the dead are eaten up by worms. The truth concerning these facts the physician should always present to his patients, and prevent much needless terror among them.

Dr. Benjamin K. Lee, spoke of the danger of keeping vegetables in cellars, unless the latter are well ventilated.

Dr. Edward R. Mayer, of Wilkes Barre, delivered the

Address on Medicine.

He sharply criticised the so-called Christian Science, and argued that internal medication had its triumphs no less notable than the external operations of surgery, which could be seen and known of all men, and quoted numerous examples to sustain his argument.

The Chemical Factor in Disease,

was the subject of a paper by Dr. Hugh Hamilton, of Harrisburg.

Dr. William Pepper, of the University of Pennsylvania, presented, but did not read, a paper entitled

A Contribution to the Clinical Study of Albuminuria,

In which he stated that of 239 supposed cases in his private practice during the past eight months examined by his assistant, Dr. J. P. Crozier Griffith, nearly 143 were found to be cases of albuminuria. He concluded that the gravity of the case as indicated by the presence of albumin was frequently much exaggerated.

Dr. Frank Woodbury presented

A Note on Effervescent Salts as Vehicles for the Administration of Certain Medicinal Agents.

He traced the popularity of many drinks to their effervescent quality, and their consequent useful medicinal value in the direction indicated. He thought that if some one could produce a solution of hops without alcohol it would be a great contribution to the solving of the temperance question. Carbonic acid water affords a useful agent for the administration of nauseous medicines, or such as it is desirable to dilute freely.

After the adjournment of the session, an informal reception was given to the delegates at the University of Pennsylvania. The delegates were met in the dental building by the Provost and several of the professors, and, after they had visited the veterinary, biological and other departments, supper was served in one of the rooms.

A reception was given in the evening at the Academy of Fine Arts by the President, Dr. Richard J. Levis.

NEW YORK ACADEMY OF MEDICINE.

Stated Meeting, May 17, 1888.

The President, A. Jacobi, M.D., in the chair.

A New Lectureship.

The Trustees of the Academy accepted a donation of five thousand dollars from the estate of the late Dr. Wesley M. Carpenter, with which to found a lectureship to be known as the Carpenter Lectureship.

Dr. B. F. Westbrook, of Brooklyn, read the principal paper of the evening, on

Pleurisy as a Predisposing Cause of Phthisis Pulmonalis.

Since it has been proven almost beyond doubt that the bacillus tuberculosis is the exciting cause of phthisis pulmonalis we should inquire whether certain local conditions will not so affect the lung tissues as to render them specially liable to the invasion of this micro-organism. He thought it must be admitted that something in the nature of a predisposing cause must exist in susceptible individuals. There had been much discussion with regard to the relationship which different diseases bore to each other. With regard to that relationship as it concerned phthisis and pleurisy he laid down the following classification, and gave illustrative examples:

First.—Cases of pleurisy antedating the outbreak of phthisis pulmonalis. In these cases a pleurisy with effusion occurs in a person apparently in good health, and is immediately followed by evidences of pulmonary tuberculosis, which usually runs a rapid course to a fatal termination. In these cases the pleurisy is undoubtedly tubercular in origin, and forms but a part of a general disease, and its discussion is not germane to the subject.

Second.—This class includes those instances in which a sero-fibrinous pleurisy is followed by a slow development of chronic interstitial

pneumonia, the fibroid phthisis of Sir Andrew Clark.

Third.—Cases in which an acute or subacute attack of sero-fibrinous pleurisy terminating in complete recovery is followed after some months by the development of tuberculosis at one or both apices, usually observed in persons who are constitutionally weak or whose health has been injured by debilitating influences. Cases of this kind are not very numerous.

Fourth.—This class includes cases occurring usually in those of middle age or in the decline of life, in which a sero-fibrinous pleurisy has become chronic, and in which on account of the density of the false membrane covering the lung and the diminished pliability of the parietes of the chest, absorption has not occurred. They are typical cases of chronic sero-fibrinous pleurisy, which have either failed to be recognized or have been left to the uncertainties of nature. It is a fact that some of them finally develop tuberculosis either in the lungs alone or the general disseminated form.

Fifth.—Cases of empyema, the appearance of which antedates the appearance of tuberculosis. This class is introduced simply to make the list complete.

Dr. Westbrook's conclusions were: That sero-fibrinous pleurisies apparently simple in origin and terminating in complete recovery so far as the local manifestations are concerned, may be followed after the lapse of a few months by the development of phthisis pulmonalis; that in all probability the pleurisy in these cases acts as a predisposing cause of the tuberculosis; that primary sero-fibrinous pleurisy may result in fibroid phthisis with the subsequent occurrence of tuberculosis pulmonalis; that fluid effusions remaining in the chest for a long time may finally so interfere with the nutrition of the lungs or of the body at large as to render it liable to tubercular inflammation either local or general. The rational deduction from these facts is that no case of pleurisy should be neglected. The patient should not be lost sight of for sometime after his health has apparently been completely restored, and under judicious gymnastics there had been much chest expansion and improvement of the general condition.

Dr. Williams, of Brooklyn, read a brief paper on

Some of the Determining Causes of Pleural Exudates,

and spoke of pleurisy being either sthenic or asthenic; of an hereditary or constitutional condition, in which there was demonstrated richness of cell proliferation in inflammatory products, with proneness to organization. The subject of such a tendency was liable when pleurisy occurred to have the surfaces blanketed with a pseudo-membrane in seeming disproportion to the exciting cause. In a second class of cases there was early pulmonary immobility, regional or entire, not due to pleural disease, but antedating this. In a third class of cases there was constitutional infection by the bacillus tuberculosis. Such were some of the conditions favoring pleural exudates.

Dr. J. Blake White in a brief paper gave expression to the view that pleurisy not only frequently occurred in pulmonary tuberculosis, but that it might give rise to the lung affection in persons who had previously been healthy. We often see, he said, neglected cases of pleuritic adhesions in patients suffering with a hacking cough and progressive emaciation, their condition having been allowed to progress until it has become irreparable. The question of preventing as well as curing phthisis depended, he thought, more upon increase of lung capacity, especially about the apices where activity is naturally least, than on purity of air or bacilli, though he would welcome the former for its therapeutic value and would be pleased to know of the absence of the latter as evidence of there being no suppurative inflammation. Regular systematic lung exercises in children, with judicious diet, would do much to prevent phthisical tendencies and chest deformity as life advanced. He was not prepared to accept the teaching that tuberculosis was due to the bacillus tuberculosis; he thought the bacillus was the result of the phthisical process.

Dr. W. B. Wood read a brief paper on the treatment of

Predisposition to Phthisis in Children who had had Pleurisy.

He thought that in all cases before phthisis actually developed there was a stage at which there must have existed predisposition. The manifestation of predisposition to phthisis is diminished breathing power or respiratory function. There are two great causes of deficient respiratory function in children, viz., impeded nasal respiration and thickened and immobile pleura at the base of the lung, and any treatment which would successfully overcome these conditions constituting predisposition would, in the vast majority of cases, effectually prevent the development of phthisis. It would be necessary to secure free breathing through the nasal

passages by the proper treatment directed to them, and to institute a system of lung gymnastics.

Dr. E. T. Bruen, of Philadelphia, opened the general discussion, and said that during the past few years considerable attention had been devoted to the question whether or not the etiological conditions of phthisis might not have a bearing upon the development of pleural processes. He added two cases to the general testimony going to show that the pleurisy might be of a tubercular origin before the occurrence of tuberculosis of the lungs. He thought it was no argument against the view that the pleurisy was of a tubercular origin that the disease was not infrequently entirely recovered from, for we saw tuberculosis in other portions of the body, as in the peritoneum, disappear completely. He would, therefore, lay more stress than Dr. Westbrook had done on the tubercular character of the cases under consideration. He thought physicians failed to recognize as they should the importance of general exercise in chest diseases, and devoted too much attention to the development of respiratory capacity. Neither should be neglected.

Dr. F. C. Shattuck, of Boston, dwelt upon the question of tubercular origin of pleurisy, and said that about three years ago he added a note to Strümpell's Text-book of Medicine, in which he gave expression to the view that in America facts did not bear out Strümpell's opinion that pleurisy due to cold was extremely rare, for here many patients absolutely recovered from the disease. Since that time he was becoming more impressed with the frequency of a tubercular origin of pleurisy. We had not generally freed ourselves of the impression that tuberculosis meant pulmonary tuberculosis, and and failure to find it was not proof that the process was not tubercular.

Speaking of failure of aspiration to prevent re-collection of the fluid in the pleural cavity, he said that often the fluid would become absorbed by limiting the fluids taken by the patient to one-third or one-half of the amount of urine passed, and giving him sufficient of the iodide of potassium and chloride of sodium to make the blood thirsty for liquids.

Dr. Westbrook, in closing the discussion, said that he had treated the subject from the clinical rather than the pathological standpoint. He did not think the evidence was at all sufficient to show that all cases of pleurisy were of tubercular or infectious origin. He did not see why the pleura of all the tissues of the body was incapable of taking on inflammation except that of an infectious nature.

The Constitution of the Society was revised so as to take in as active members physicians in any part of the State of New York, and extending non-resident membership to those residing without the State.

Periscope.

Athetosis in a Girl Twenty Months Old.

At the meeting of the Société Médicale des Hôpitaux, of Paris, April 13, 1888, M. Comby stated that he had then under observation a little girl twenty months old, who had been suffering since the eighth month of her life with hemi-athetosis of the right side. This child, though nourished at the breast, had nevertheless received too much solid food. She is now subject to attacks of vomiting and diarrhœa; she is slightly rachitic. The father is tuberculous; the mother healthy, but she gave birth to a child which died of meningitis when five years old.

The onset of the athetosis was marked by violent convulsions which lasted several days. At present, he says, in the standing position she supports herself principally upon the left limb; she incessantly turns the right foot up and moves the toes. The hand upon the same side is likewise extended and flexed, and moved from side to side, as is characteristic of athetosis. The general sensibility is undisturbed; there is nothing abnormal about the eyes, and no muscular atrophy. M. Comby remarks that athetosis is extremely rare in a children's clinic; in 30,000 consultations given in five years, he has never observed but one.—*Bulletin Médical*, April 15, 1888.

Extirpation of the Kidney.

At a meeting of the Berlin Medical Society, March 7, 1888, Dr. E. Küster presented a patient whose left kidney he had excised for tuberculous disease. The patient was a man, 38 years old, of healthy parentage, though his younger brother is at present suffering from disease of the lung. In 1886 he was attacked with fever, the source of which was not recognized; he became very much emaciated. In April of the past year, a tumor of the left kidney was discovered, for which nephrotomy was done, and the kidney drained. But suppuration did not subside, so that a second incision was made in front, and the kidney drained clear through. This second incision was carried through the peritoneum without untoward result.

When the patient applied to Küster for treatment in October of last year, he was extremely emaciated. There were two fistulæ in the neighborhood of the kidney which gave vent to stinking pus. The author then supposed that the trouble was a simple pyonephrosis, the more so, as the urine which came only from the right kidney presented no abnormal constituents. But on uniting both fistulæ by an incision, he explored the kidney with his finger, and found that there were a number of holes in it, and from these he expressed with his finger caseous yellow pus. He at once thought the disease tuberculous, and as the other kidney was sound he extirpated the left kidney by horizontal lumbar incision. Recovery was rapid. The patient has two fistulæ, which are scarcely discernable, and has gained forty pounds in weight in two months.—*Deutsche med. Wochenschrift*, March 15, 1888.

Intraparenchymatous Injections of Ozone Water for Cancer.

Dr. Joseph Schmidt, of Aschaffenburg, has employed in two cases intraparenchymatous injections of ozone water for cancer, and has obtained such surprising results that he seems induced to submit this method of treatment to a further trial. According to the *Münchener med. Wochenschrift*, No. 16, 1888, the method consists in the injection of ozone water in the strength of one to three grains to a quart of water. The injections were made with a Pravaz's syringe. The number of injections varied, according to the size of the affected area, from one to ten or more a day. They were made into the mass of the cancer itself, as well as into the healthy tissue bordering upon it, and even into the swollen and suspicious glands. The pain when the injections are made with a rather dilute solution is not very marked, and disappears completely after several minutes or half an hour. Frequent local symptoms, especially when the injections are made with rather strong solutions, are, after a short time, moderate œdema, and slight redness and tenderness to the touch; these symptoms disappear in a few hours when the weaker solutions are used; but when the stronger solutions are used, they last for several days. During the progress of this treatment the cancerous ulcers became cleaner, smaller, and cicatrize. The cancerous nodules grew smaller, and became gradually very hard, so that the introduction of the needle was often difficult, and was accompanied with a grating sound; in such places but a few drops could be injected with difficulty. After treatment had been continued some time the parts, which at the beginning were swollen became peculiarly dense, tense with œdema, of a bluish-red color, and tender to the touch, as well as painful. When such parts were cut, under the skin, which appeared normal, was seen an œdematous, cellular tissue, and under this a thick, dense, callous mass. The microscope revealed but very few nests of cancer cells. When this treatment was continued longer, the swelling receded, and a connective tissue shrinkage occurred. Bad consequences from the injections were never noticed.—*Wiener med. Presse*, May 6, 1888.

Erysipelas and Puerperal Fever.

At the meeting of the Academy of Medicine of Paris, March 13, 1888, M. Doyen said that he had investigated the reports which connect erysipelas and puerperal fever. From a comparison of clinical and experimental facts he draws the following conclusions:

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CHARLES W. DULLES, M. D., EDITOR.

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IMMEDIATE PERINEORRHAPHY.

To those who are accustomed to do immediate perineorrhaphy for rupture of the perineum, it seems strange that anyone should oppose the performance of this operation. Yet there are many who not only do not employ this plan of treatment in their practice, but deny its propriety, and seek to prove that it is either unnecessary or harmful. Fordyce Barker is among the most prominent of those who oppose the operation in this country. Charpentier expresses an opinion very prevalent in France, when he advises operation only after three months' waiting, in lacerations extending through the sphincter ani, and states that less extensive tears heal spontaneously. Other recognized authorities are opposed to the immediate operation. It is still not uncommon to hear physicians say that they never have rupture of the perineum in their practice, and this, in spite of the fact that such men as Schröder, Olshausen, and Winckel, report lacerations in more than twenty per cent. of primiparæ and five per cent. of multiparæ. These practitioners fail to see that their statement is an admission that either they do not look for lacerations, or else that they are not able to recognize one when they see it.

As objections to immediate perineorrhaphy, it has been urged that union will occur spontaneously in incomplete lacerations, if the parts be kept clean and the knees tied together; that the wound is contused and hence is not apt to heal after suturing; that the shock from the operation done immediately after labor might cause flooding; that sepsis is favored; and, finally, that if nature fails to bring about a cure, a result as good or better can be gotten by an operation done some weeks after labor, as by immediate suture. We are in accord with those who believe that these statements and objections are not sound. No one will deny that a laceration extending only through the skin or mucous membrane and the underlying connective-tissue will unite spontaneously, but at the same time it will unite more rapidly and with the formation of less scar tissue, if permanent coaptation of the sides of the wound is secured by the use of sutures. But the suture, in this class of cases, is relatively of little importance, since no special inconvenience would result if union failed to occur. Nothing is better known than that tying the knees together has no influence one way or the other in securing union in laceration of the perineum. Anyone can demonstrate that the knees can be separated to the fullest extent without putting the perineum on the stretch. The daily attendance of women with lacerated perineum at dispensaries, and the host that consult gynecologists for the same condition, sufficiently disproves the statement that spontaneous cure is the rule after this accident. Indeed, analogy alone would teach the contrary in all cases where the tear is sufficiently deep to involve the muscles and fasciæ making up the perineal structure. The rule is that muscles, when cut across, retract, forming a hiatus between their several ends; and the muscles which centre in the perineum, when torn, retract and form a gaping wound, which cannot unite spontaneously from the very nature of the anatomical conditions present. The suture is necessary to hold the torn tissues in apposition and to secure union.

The objection that the contused nature of the wound is apt to interfere with primary union is only partly true. The great majority of lacerations are but slightly, if at all, contused, and union is secured in about ninety per cent. of cases. Contusion of the perineum is usually the result of neglect in the management of the second stage of labor by the physician, allowing a tedious second stage to continue till the impaction of the presenting part in the inferior strait, with tumefaction of the maternal tissues, from obstruction to the circulation, occurs, or to bungling use of the forceps, or to unjustifiable traction efforts. That it is occasionally advisable to dispense with the suture of lacerations of the perineum, owing to the contused condition of the tissues, is usually simply a demonstration of the fact that the second stage of labor is not always properly conducted. The fear of special post-partum hemorrhage is groundless, as experience has shown. Were the wound already infected before it was closed, of course septic absorption would be favored; but with the careful use of antiseptic precautions, this is scarcely possible; and the accurate coaptation secured by carefully performed immediate perineorrhaphy is a very certain preventive of subsequent infection. The fact that immediate closure of perineal rents is classed, by hospital accoucheurs, among the steps of antiseptic midwifery is certainly a sufficient refutation of the statement that sepsis is thereby favored. It seems to us that the teaching that the perineum can be as well restored by secondary, as by primary perineorrhaphy, is most pernicious. Doubtless this is true so far as superficial tears are concerned, but in the majority of cases these are of no importance whatever, except in that they may afford an entrance to septic infection, during the puerperium. But the case is entirely different in tears involving the muscular, tendinous and fascial structures forming the perineum. When the immediate operation is skilfully done, these torn structures are united, each to each, and the perineum is practically restored to its normal condition. But after months, and perhaps years, this is no longer possible, or at least only partially so, and after extensive dissection. The retracted muscles are buried more or less deeply under cicatricial tissue, atrophy from loss of function has occurred, and the normal anatomical relation of the tissues can seldom be restored. This fact, we are sure, is too often overlooked. The perineum is quite commonly regarded as a mass of indifferent tissue, and its true anatomical structure ignored.

Finally, after immediate perineorrhaphy, the patient fully recovers during her lying-in, and need not look forward to a subsequent operation with a month blotted out from the active part of her life. Were the operation difficult or dangerous, there would be an excuse for neglecting it; but it is neither. It is perhaps as simple an operation, yet yielding as gratifying results, as there is in surgery. There is one variety of laceration which can seldom be recognized or treated primarily—the subcutaneous, or sub-mucous—and yet these tears are almost always followed by serious consequences. Either the pelvic fascia, or the muscles of the perineum, or both, give way, without a break in the mucous or cutaneous surface, and as a result the anterior rectal wall, and the base of the bladder, lose their support. Rectocele and cystocele follow. Byford has recommended for such cases, if the diagnosis has been made at the time of rupture, that deep sutures be passed with a curved needle from the cutaneous surface, and an attempt be made to draw the separated structures into apposition.

TREATMENT OF SNAKE BITES.

The recent occurrence of a case of rattlesnake bite in New Jersey, and the subsequent treatment of the patient in a New York hospital, draws attention to the state of knowledge in regard to this important subject. In one of the best hospitals in the country it appears that medical science led to no better method of treatment than that familiar to the rudest intelligences, namely, the production of profound and continued intoxication. This was carried out thoroughly, and the patient recovered. If the only adage worthy of respect in the world were that one

which asserts "*finis coronat opus*," then the case referred to is another evidence that whiskey is an antidote to the venom of the *Crotalus*. But, unfortunately, *post hoc* is by no means *propter hoc*, and the conclusion is weakened by the well-known assertion of Dr. S. Weir Mitchell, that at least seven-eighths of all persons bitten by rattlesnakes recover, and the case alluded to may show only that a man can stand a good deal of whiskey in addition to a rattlesnake bite, and not that one is antidotal to the other.

For all this, it must be admitted that there is no method for the treatment of snake bites so simple, so feasible, so easy to carry out, and so trusted as that of saturating the victim of the bite with whiskey or some other alcoholic liquor. Methods more pleasing to the scientific mind have been proposed, and ably advocated; but it remains true that none have such strong claims upon the credence of mankind, inside and outside of the profession of medicine, as what may be called the whiskey method.

In connection with this statement we would call attention to a communication on "Snake Bite and its Antidote," by H. C. Yarrow, M.D., Curator of the Department of Reptiles, in the United States National Museum, which is published in *Forest and Stream*, May 17 and 24, 1888. In this very interesting paper Dr. Yarrow gives a review of the history of the subject and describes the results of a number of experiments which he made in order to ascertain the reliability of permanganate of potash as an antidote to the venom of the rattlesnake. The outcome of the whole may be stated to be that this remedy seems to have no antidotal influence after the venom has once fairly entered the system, and that it can only be held to have the power to render the venom inactive by chemical action when brought directly into contact with it.

It might be objected to Dr. Yarrow's experiments—as to many similar ones—that the animals selected for experimentation may not be fair tests of what would happen in the case of larger animals, or of man. And it would be interesting to have some extended observations, not only of the power of antidotes, but also of the effects of untreated snake bites upon animals somewhere near the size of man. Such experiments would be more demonstrative than any with which we are familiar.

So much for the scientific aspect of the question of the treatment of snake bites; from the practical standpoint, it is interesting and it may be comforting to know that the danger from snake bites is probably very much less than the popular dread of them, and that the administration of whiskey, or some other alcoholic liquor, until distinct intoxication is produced, is a very trustworthy method of treating them. When medical science has demonstrated a method more acceptable to the scientific mind, it will be pleasant to announce it; but just now it happens that there is no method which is so deserving of acceptance and practice as that which every woodman knows, and the means for which every cross-roads can supply.

QUACK ADVERTISEMENTS IN RELIGIOUS NEWSPAPERS.

It is pleasant to be able to announce that a large religious body has recently taken official cognizance of the scandal and injury brought about by the publication in religious newspapers of fraudulent advertisements.

At the Centennial General Assembly of the Presbyterian Church, lately held in Philadelphia, a bill and overture on the subject was presented from the Presbytery of Westchester, N. Y., and the Committee on Bills and Overtures recommended the adoption of a resolution, in accordance with its suggestion, that the General Assembly, while disclaiming responsibility for or authority over religious journals not published under its direction, disapproves of "all those advertisements of patent medicine, dishonest in form, fraudulent in substance, or prejudicial to the refinement, modesty and purity of the home life."

This resolution is a step in the right direction, and we would like to see it soon coupled with a recommendation to good Presbyterians to refuse to patronize religious papers which publish—as the most influential Presbyterian papers do—absolute and unqualified false-

hoods, traps for the unwary, and advertisements which contain ill-concealed allusions to sexual matters. The editors of the three most conspicuous offenders in the ranks of Presbyterian newspapers were at the Assembly referred to, and we shall be interested to see what effect the resolutions referred to will have upon them. They have shown considerable power of resistance to appeals to their sense of right; but we shall see if this one will have any better result. Meanwhile, we believe that another Assembly might, for its own sake and the sake of religion, go beyond a resolution of disapproval and a disclaimer of responsibility and authority. To a certain extent, the credit of several religious bodies is involved in this matter, and we hope they will soon find an effectual way to mend it.

Our own efforts have hitherto been directed toward persuading our fellow editors—of religious papers—to remove these occasions of offense. We have referred to them temperately and moderately on several occasions, and have taken the trouble to mail to the editors of almost all the religious papers in the United States slips of our editorial remarks; and if, now or hereafter, we appear to speak severely, let it be understood that it is only because we think the circumstances demand plain speaking. We have not begun an attack on what we regard as a great evil, prejudicial to religion as well as to public health, with the idea of abandoning it; but determined to carry it on with as much suavity as possible, but with as much vigor as may be necessary.

PENNSYLVANIA STATE MEDICAL SOCIETY.

The thirty-ninth annual meeting of the Medical Society of the State of Pennsylvania, which has just been held in Philadelphia, was a very interesting one, in both a scientific and a social sense. The social features included receptions and entertainments of various kinds, and visits to the principal medical schools and hospitals. The scientific proceedings were marked by the reading of papers of great interest, and fairly active discussion.

One of the most important occurrences was a discussion of the relation of medical superintendents to the general management of the State hospitals for the insane, precipitated by a preamble and resolutions introduced by Dr. Hiram Corson, urging the assumption by the trustees of the general control of hospitals and the restriction of the medical officers to medical functions alone. The discussion which followed was taken part in by Dr. Schultz, of the Danville Hospital; Dr. Curwen, of the Warren Hospital, and Dr. Gerhard, of the Harrisburg Hospital. These gentlemen, and several others who took part, strongly repudiated the idea that control of the general management of a hospital for the insane was incompatible with a thorough and faithful performance of the duties of a medical officer. The outcome of the discussion was that the Society declined to pass the resolution proposed by Dr. Corson, and showed decided sympathy with the medical superintendents, at which they were directed.

Book Reviews.

[Any book reviewed in these columns may be obtained upon receipt of price, from the office of the Reporter.]

PHOTOGRAPHIC ILLUSTRATIONS OF SKIN DISEASES, AN ATLAS AND TEXT-BOOK COMBINED, By George Henry Fox, A.M., M.D., Clinical Professor of Diseases of the Skin, College of Physicians and Surgeons, New York, etc., complete in 12 parts. Second series. New York: E. B. Treat, (1888). Price, $2.00, each part.

This is the second issue of a work so well-known that it hardly needs to be described. It is not merely a revision of the issue of five years ago, but contains a number of new plates. Some affections which were not represented in the old issue are here considered, and the text is considerably enlarged and amplified. The method chosen for presenting the diseases of the skin in this work is one which has proved very satisfactory in the past. We recognize the fact that no plates can be prepared which exactly represent what may be found in any given case of skin disease, but there can be no doubt that such books as the one before us are calculated to assist very materially the practitioner who has not the advantage of studying dermatology under a competent teacher in the wards of a large hospital.

The present work is very handsomely executed and may be heartily commended to the patronage of our readers.

Pamphlet Notices.

[Any Reader of the Reporter who desires a copy of a pamphlet noticed in these columns will doubtless secure it by addressing the author with a request *stating where the notice was seen* and enclosing a postage stamp.]

The Distribution of the Color-marks of the Mammalia. By Harrison Allen, M. D. From the *Proceedings of the Academy of Natural Sciences*, Philadelphia, February 28, 1888. 23 pages.

Strangulated Hernia. By Geo. N. Taylor, New York. From the *Medical Advance*, 1888. 16 pages.

The Pathology of Hay Fever By S. S. Bishop, M. D., Chicago. Read in the Section on Psychological Medicine and Nervous Diseases, Ninth International Medical Congress. From the *Journal of the American Medical Association*, March 17, 1888. 11 pages.

What is the Legitimate Scope of Gynecology? Annual address read before the St. Louis Obstetrical and Gynecological Society, November 17, 1887. By Walter Coles, M.D. From the *St. Louis Courier of Medicine*, January, 1888. 10 pages.

One Year of Dermatology. Report of the Department for Diseases of the Skin in Charity Hospital. By Henry William Blanc, M.D. New Orleans. 25 pages.

—The points, in this learned study of a matter of great interest to naturalists, which especially concern medical men are the idea that the distribution of the lanugo may be a guide to the disposition of eruptions upon the skin, and the proposition that lesions of various kinds may be studied as one can study the color-marks on a quadruped. After an elaborate study of the location and developmental relations of breaks in the general color of a variety of animals, Dr. Allen proposes to study the eruptions on man in the same way, and also with especial reference to the distribution of nerve and blood vessels, and the proximity of bones. The difficulty in carrying out this programme will be to secure the combination of training in natural history with clinical opportunities, which it requires. But we would recommend Dr. Allen's able paper to the consideration of specialists in diseases of the skin, in the hope that it may prompt them to carry on the study from the point to which it will conduct them.

—Dr. Taylor's pamphlet contains an exceedingly interesting description of a method for the reduction of strangulated or incarcerated hernia, which involves principles diametrically opposite to those involved in the methods usually employed. Traction and aspiration are the key-notes of his method, and they are secured by placing the patient in a position in which the hips are higher than the shoulders, and in which the action of the muscles of respiration—aided, if need be, by the hand of the surgeon or physician—tends to draw the intestine out of the hernial sac and into the cavity of the abdomen.

This method certainly appeals to one's reason, and Dr. Taylor says it is efficient in practice.

—Dr. Bishop argues for the nervous nature of hay-fever or—as he prefers to call it—nervous catarrh. His argument is interesting and convincing. The claims that hay-fever depends upon mechanical conditions in the nose he opposes on the ground that many people have diseased nasal cavities without ever suffering from hay-fever. There is much in favor of the theory which Dr. Bishop supports, and we believe that his pamphlet is well calculated to win those who read it to his views.

—Dr. Coles's address does not contain any complete answer to the question in its title, but is occupied rather with a defense of gynecologists against certain imputations which are not uncommon nowadays, and which had recently been expressed by two neurologists of St. Louis. The defense is earnest, straightforward and interesting, and gives expression to a conception of the duties and requirements of the gynecologist which must meet with general approval.

—The Department of Skin Diseases of the Charity Hospital in New Orleans was organized in October, 1886, and since that time Dr. Blanc has had charge of it. His report of the first year's work includes a table of 373 cases, and a more or less detailed account of a number of cases of special interest. One of the most interesting of these is a case of albinismus, which suggests some analogies similar to those indicated by Dr. Harrison Allen in his paper on "color-marks." Other cases might be mentioned; but we have to be content with simply alluding to them. The report as a whole is very creditable to its author, and gives promise that the famous hospital with which he is connected will do good work in promoting the study of dermatology.

Literary Notes and Queries.

[In this column the Reporter will publish short items of literary interest and questions addressed to this Journal or its readers, and answers to them, in regard to any literary matters: books, authors, places and prices of publications, etc.]

—A new journal called *Revista Braziliera de Medicina* has just been issued at Rio-de-Janeiro. It is edited by Dr. Azevedo Sodre.

—It is announced that the first number of a new journal to be devoted to diseases of the skin will appear June 1. It is to be issued by Dr. Ralph St. Perry, of Indianapolis.

Correspondence.

The Attire of Women.

Editor Med. and Surg. Reporter:

Sir:—In your issue for May 12 I find an interesting article with the above title. It states that some "French lady" (such persons usually prefer to be designated as "women") desires to have the Chamber of Deputies legalize the wearing of male attire by women. This brings up the question, why it is that women are wearing the present style of dress? Of what special advantage is it to women to wear petticoats, and how did the style originate? Somewhere I have seen the statement that women in the olden times dressed, or were dressed, in loose garments so that men could easily hold sexual intercourse with them and gratify their sensual

desires without having the form hidden away from their sight and actual contact.

This is a question which some of your readers may be able to shed light on. If such was the origin of the custom, is not the fashion conducive to licentiousness?

Yours truly, H. M. WHELPLEY.

St. Louis, Mo.,
May 23, 1888.

[The word "lady" got into the REPORTER by mistake. We object to using it as much as our correspondent does.—ED. REPORTER.]

NOTES AND COMMENTS.

Case of Cæsarean Section.

Dr. Howard A. Kelly performed his second Cæsarean section May 30. The subject of the first operation, which was noted in the REPORTER May 5, 1888, has recovered. The second operation was done for the relative indication. The patient had given birth to two children previously; the first was delivered by crushing the head with the forceps, the second was not fully developed, and neither lived. The patient has a flat rachitic pelvis, with a true conjugate estimated at about two and three-quarter inches. Craniotomy was not done because of the patient's religious belief, as she is a Roman Catholic. The child, a healthy seven-pound girl, was delivered in two minutes, and the whole operation completed in thirty-two minutes. Seven deep and fifteen superficial sero-serous sutures were used to close the uterine incision. The patient was put to bed in good condition. At last accounts she was doing well.

Fire at the University of Pennsylvania.

A portion of the Medical Hall, of the University of Pennsylvania, was destroyed by fire Thursday morning, May 31. The fire seems to have started in the pathological laboratory on the third floor, where it was fortunately discovered soon after it occurred. The destruction directly traceable to the fire is limited for the most part to this floor and the roof; but the rooms on the second floor, which are occupied by the professors as private rooms, and by the Stillé Library and Wistar and Horner Museum, were flooded with water and damaged by falling plaster, etc. The time of the fire being about the lecture hour, a number of students worked energetically and succeeded in removing much valuable property, including most of the portraits of former professors, which hung in the museum.

The loss which will be suffered is difficult to estimate, because much of the property destroyed, especially in the museum, and to a less extent in the laboratories, can never be replaced. But as nearly as can be arrived at, the loss will be between $50,000 and $75,000, which is said to be fully covered by insurance. Fortunately, the fire occurred while only the spring course of lectures was in progress. Before the preliminary course opens in September all necessary repairs to the building will have been made.

The museum is nearly one hundred years old. Dr. Casper Wistar, first Professor of Anatomy, had much to do with founding it. Dr. Horner, subsequently Professor of Anatomy, added largely to it, so that it has been known as the Wistar and Horner Museum, although there have been gathered in a great many additions from various sources. The museum also contains a large collection which belonged to the late Dr. George B. Wood, and a very large surgical collection by Emeritus Professor of Surgery, Henry H. Smith. The late Professor of Clinical Surgery, John Neill, presented his collection, consisting largely of specimens of fracture and diseases of the bone. The museum was also especially rich in extremely delicate and beautiful dissections, as well as injected preparations which were deposited in it after having won prizes from the faculty, and a great many costly preparations of the brain and organs of special sense, such as the eye and ear. Dr. Leidy presented to the museum the preparations which he has made during the course of thirty years; these included a remarkably valuable series of preparations of the temporal bone, which were the result of Dr. Leidy's special study, and which showed some recent discoveries which he had made.

Michigan State Medical Society.

The twenty-third annual meeting of the Michigan State Medical Society will be held in Detroit, Thursday and Friday, June 14 and 15, 1888, beginning at 10 o'clock in the morning. Papers must be presented fully completed, in order that they may be handed to the Recording Secretary when read, thus avoiding delay in the publication of the Society's Transactions. Compliance with this request last year enabled the Publication Committee to effect an early issue. The annual addresses on Practice of Medicine and Surgery will be delivered, together with the President's Address, at the Detroit Opera House, on the evening of the first day. The public are to be invited, and it is hoped that this arrangement will permit more time to be

devoted to scientific, sectional work. Dr. T. A. McGraw is President, and Dr. George Duffield Secretary of the Society.

Prophylaxis of Syphilis.

At a recent meeting, the Academy concluded its labors on the "Public Means for Preventing the Spread of Syphilis." It was unanimously decided to adopt that portion of the report of its commission calling for the total abolition of disciplinary measures against the infected, the adoption of the best means of stamping out clandestine prostitution by warning young soldiers against its attendant dangers, and by combining the efforts of the civil authorities with those of the army medical officers with a view to the suppression of such dangers, both in town and in proximity to camps. Finally, the Academy adopted the following resolution in respect to the Navy: "Crews should be subjected to sanitary inspection prior to the ship putting into port; men found to be infected on inspection, after a voyage of sufficient length, should not be allowed to land; suspected houses, and persons leading a debauched life in naval port or ports of call should be kept under medical surveillance; and the municipal authorities of such ports should be required to keep all suffering from disease in hospital until thoroughly cured of all infectious symptoms." The discussion closed. M. Herard, President, congratulated the Academy for having initiated the agitation on this important question—agitation which is likely to result beneficially for the public health, and has aroused the attention of the public powers, and thereby paved the way for such reforms as may be deemed necessary.

Antipyrine in Chorea.

In the clinic of Dr. H. C. Wood at the Hospital of the University of Pennsylvania, both antipyrine and antifebrine have been used in a number of cases of St. Vitus's dance in children, and the results so far have been uniformly good, sometimes remarkable. Thus recently a case was shown to the class in which a week's treatment had produced almost complete quiet, although just previously there had been no decided improvement after three weeks' administration of arsenic. No difference has been detected in the action of antifebrine and antipyrine. In a recent communication to the French Academy, M. Legroux stated that he had had remarkable success with antipyrine in chorea, affirming that he has been able to reduce to a period of from one to three weeks (many of his cases getting well in a week) the duration of a disease which ordinarily lasts from sixty to ninety days. His treatment is as follows: One gramme (fifteen grains) of antipyrine is dissolved in twenty grammes (five drachms) of syrup of bitter orange-peel, and the whole is administered at one dose. Three such doses are given during the twenty-four hours. He considers it perfectly safe to give this dose to a young child, and all of Legroux's patients are now treated in this way.

In Dr. Wood's clinic much smaller doses than those used by Legroux have been used, and we are not at all sure that it is safe to give a young child forty-five grains a day.—*Therapeutic Gazette*, April, 1888.

Pengawar Djambi, or Poku-Kidang

The *Therapeutic Gazette*, April, 1888, says editorially of this drug:

"We have long used it in the physiological laboratory of the University of Pennsylvania as a hæmostatic. It was originally brought to us by Dr. Lautenbach, who had learned the value of it while working in the laboratory of Professor Schiff, at Geneva. To the physiological surgeon it is extremely valuable on account of its power of rapidly coagulating blood and forming a plug, which for the time being will stop hemorrhage even from large venous vessels. Thus, in opening up the spinal cord there is usually an excessive outpouring of blood from the torn sinuses, an outpouring which may be at once arrested by stuffing pengawar djambi into the wound. It is free from irritant properties, and we see no reason why it could not be made the bearer of antiseptic substances. Under its influences we believe that any cut surface would rapidly dry, and we trust some of our surgical readers will make a practical test and report the results in our columns."

Rupture of the Bladder in the Line of a Cicatrix of a Suprapubic Lithotomy.

At the meeting of the Anatomical Society of Paris, March 9, 1888, M. Albarran exhibited the bladder taken from an old man on whom suprapubic lithotomy had been performed five years before by Prof. Guyon. All went well in the interval with the exception of a hernia at the cicatrix; then retention of urine from prostratic trouble, at first incomplete then complete, occurred. The bladder ruptured in the line of the cicatrix, and the patient succumbed to infiltration of urine. M. Guyon lays stress upon the lack of firmness in cicatrices of the bladder, a point which he has demonstrated upon a patient for whom he did the suprapubic operation twice.—*Bulletin Médical*, March 25, 1888.

NEWS.

—Dr. Isaac Barton, of Philadelphia, has removed his office to No. 111 North Sixteenth street.

Dr. W. L. Lichtheim, of Berne, has been appointed Professor of Medicine at the University of Königsberg.

Professor Virchow has been decorated by the Emperor of Germany with the order of the Red Eagle of the Second Class.

—The Cincinnati Press Club has established permanent quarters during the Centennial Exposition of the Ohio Valley and Central States, at the Exposition Buildings, and will dedicate them on Saturday evening, June 9, with a reception and banquet.

—Miss Alice Fisher, the English nurse who has been for several years in charge of the Training School for Nurses at the Philadelphia Hospital, died of heart disease, June 3. Miss Fisher had been in failing health for some time before her death, which was therefore not unexpected.

—The *Medical Record*, May 26, 1888, says: An Italian patient in one of Dr. Shrady's wards in St. Francis Hospital, deliberately chewed a fever thermometer and swallowed the greater part of it before he was made to understand that the instrument was not intended as a medicine. Luckily, he has had no subsequent increase of temperature, which would make it necessary to risk another thermometer in that way. The rectum will be the next choice.

—The will of the late Dr. Wesley M. Carpenter, of New York, contains a clause bequeathing $5,000 to the New York Academy of Medicine, for the purpose of founding a lectureship, to be known as "The Carpenter Lectureship." The interest is to be used annually for one medical lecture, which shall be published in pamphlet form immediately after its delivery. The will provides that the Academy must guarantee the fulfilment of the conditions of the bequest, or else the proposed donation shall remain to be disposed of as part of the testator's estate. The Academy has accepted the bequest.

HUMOR.

MICROBATS.—A correspondent of the New York *Evening Post* writes from Lake Mahopac:

I stopped to talk with a man who appeared to be directing some others at the lake, and congratulated him on the successful harvest of the crop.

"Jes' so, jes' so," he said. "Well, yes, it will be a big thing this year—our folks can get any price they want."

"How is that?" I asked.

"Why, on account of them microbats in the North River ice. It's all pizeñ, and nobody will use it. Ours hasn't got any of 'em in it."

"Well, what's the matter with the North River ice?"

"Microbats, didn't I tell you! You get a microscope and examine a drop of that water; there's ten million microbats in it, and every one of 'em is a snake. They lay so close together that they keep 'emselves warm, and don't freeze when the water freezes solid. Then when the ice thaws out, there they be. Folks that drink that kind of ice-water get typhoid fever, malaria, measles and small-pox, to say nothin' of having live critters crawlin' round inside of 'em."

"But how would they work in whiskey?" I suggested; "wouldn't that kill them?"

"Now, that's something I hadn't thought of," replied the ice man. "Perhaps it might."

"Well, then," I replied, as I touched Fanny lightly with the spur, "New Yorkers, on the whole, may consider themselves safe."

OBITUARIES.

AUGUSTUS R. DAVIDSON, M.D.

Dr. A. R. Davidson, of Buffalo, N. Y., died May 25, at the age of 43 years. He was born in Ontario, Canada, and was graduated from the Medical Department of the University of Buffalo in 1878. He was a professor of chemistry, toxicology and dermatology in the Medical Department of the University of Niagara, and had been associate editor of the *Buffalo Medical and Surgical Journal.*

WILLIAM E. AIKEN, M.D.

Dr. William E. Aiken, aged 80 years, was found dead in bed at his home in Baltimore, May 31. He was for many years professor of chemistry in the Maryland Medical University, and at the time of his death was Inspector of Illuminating Gas under the city government.

SUSAN P. STACKHOUSE, M.D.

Dr. Susan P. Stackhouse was Demonstrator of Surgery at the Women's Medical College. She was graduated from that institution in 1883, and in 1887 she was elected to the chair at the college, and was said to possess remarkable abilities as a surgeon. She died at her home in Fallsington, Bucks county, and her body was cremated May 19.

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Clinical Lectures.

THREE CASES OF SCURVY.

BY FREDERICK P. HENRY, M.D.,
PHYSICIAN TO THE PHILADELPHIA HOSPITAL, AND TO THE EPISCOPAL HOSPITAL.

Delivered at the Philadelphia Hospital May 23, 1888.

Gentlemen:—I have to show you this morning three cases of a disease of malnutrition, which, before the days of canned vegetables and fruits, was very prevalent, and is perhaps more common at present than is generally supposed. The disease to which I refer is scurvy, and it is one which has become almost obsolete—certainly obsolescent—by the removal of its causes. The principal, if not the sole cause of this disease, is a want of variety in the food. It was for a long time supposed that common salt taken in large quantities for a prolonged period, had a direct tendency to cause scurvy; but this has been disproved by the observation of cases in individuals who had not eaten of salted food of any kind. The disease is now regarded as a species of starvation, or partial inanition, caused by the want of certain unknown substances found in potatoes, green vegetables, lemons, oranges and limes. Perhaps the most recent epidemic of scurvy of which we have any scientific account, occurred during the siege of Paris by the Germans in 1870–71, and it was observed in several of the large hospitals of that city, that the disease made its appearance immediately after the enforced withdrawal from the diet of potatoes and green vegetables. Numerous instances of the same sort may be found in the literature of this disease.

Dr. Garrod in 1848, was the first to propound the theory that the substance, the absence of which from the food gives rise to scurvy, is potassium; and this view of the etiology of the disease has been widely accepted, numbering among its adherents the great chemist, Liebig. The great antiscorbutic value of the potato is due to the potassium, which it contains in large amount. That the absence of potassium from the food is one of the causes of scurvy, there can be no doubt, but the view that it is the sole cause cannot be maintained; for epidemics have been observed among individuals into whose dietary potassium entered in large amount. The obscurity which surrounds the etiology of this disease, taken in connection with the fact that it frequently prevails in epidemic form, has, as a matter of course, given rise to the suspicion that it originates from, and is propagated by, infective agencies—micro-organisms. This hypothesis has not the slightest basis of fact upon which to stand, and is, as I have said, nothing more than a bare suspicion. There is, however, one fact which has seemed to lend some support to this view, viz., that the disease has been observed in infants at the breast, and the breast has been always that of a scorbutic mother. It is hardly necessary to say that a poorer milk can be scarcely conceived of than that secreted by a scorbutic woman, and this fact of the occurrence of scurvy in nursing children is, in reality, a strong confirmation of the view that the disease is one of defective alimentation.

Predisposition.—That there is a predisposition to this disease is shown by the fact, that in epidemics of scurvy a certain number of persons escape who have been living on precisely the same food as those attacked. The strong, as is to be expected, resist the disease better than the weak, while those who have recently suffered from intermittent fever or syphilis, are especially vulnerable. Bad hygienic surroundings, excessive physical

labor and depressing emotions are undoubted predisposing causes. It is probable that the two first-named causes were operative in our patients, who all belong to the laboring class. Two of them are Hungarians who have been working in a stone quarry, and the third is an Italian. None of them speak a word of English, and, therefore, it has been difficult to obtain precise details concerning their diet and mode of life. The Italian, doubtless, has been living largely on starchy food, macaroni or rice, both of which are very deficient in potash. Of sixteen alimentary substances arranged by Garrod, with reference to the amount of this substance contained in them, potatoes head the list and rice comes last.

Clinical History.—That scurvy is a constitutional, and not a local disease is shown by the fact that its pathognomonic external manifestations are preceded by a variable period of ill health or cachexia, of which the symptoms are largely identical with those of anæmia in general. In some respects, however, they are decidedly unlike those of anæmia. For instance, the countenance, instead of being pale, is of a livid, cyanotic hue, as if the blood were not thoroughly decarbonized, and it is said that direct observation has shown the blood, at this stage, to contain more than the normal percentage of coloring matter. Be this as it may, and I have had no opportunity to confirm or refute the statement, it is certain that anæmia is sure to occur sooner or later. In the patient before you, a Hungarian, who has been in the hospital for several weeks, I examined the blood on May 16, and found it to contain 2,775,000 red corpuscles per cubic millimetre, *i.e.*, 55 per cent. of the normal number, while the coloring matter was only 30 per cent. of the normal. These figures represent a very high degree of anæmia. In the second of the patients, the Italian, I examined the blood on May 22, and found a still higher grade of anæmia. The red corpuscles in this case numbered only 1,980,000 *i.e.*, their percentage was only 39. After repeated attempts to obtain enough blood for the color test, I was obliged to desist, although several deep incisions with a broad, lance-shaped needle were made in three separate fingers. The blood would at first flow readily and then stop altogether, before a good-sized drop had escaped. It seemed as if all blood in the finger-pulp had been squeezed out for no more could be obtained. The white corpuscles were certainly not increased in either case, and in the latter I believe they were not only relatively, but absolutely diminished, as I examined a great many fields without finding any, and at last, after a prolonged search, succeeded in finding *one*.

After the prodromic stage of cachexia has lasted for a period, ranging from one to several weeks, the true nature of the disease becomes manifest by the appearance of certain local affections, of which one of the earliest, and certainly the most characteristic is that of the gums. This is well marked in all three of our cases. The gums, as you see, are of a deep-red color and are swollen to such an extent that they project in fungous masses between the teeth. They are very painful and tender, and bleed on slight pressure. They may swell to such an extent as to entirely cover the teeth, or actually to protrude from the lips.

It is a singular fact that the affection of the gums is limited to the immediate neighborhood of the teeth. If there is a gap between them the corresponding portion of the gums remains healthy, and, therefore, in infants who have not yet cut their teeth, and in old people whose teeth, so to speak, have *cut* them, the affection of the gums is wanting. The other manifestations of scurvy have their principal seats in the skin, the connective tissue and the muscles. In the skin they may assume the form of small petechial spots surrounding a hair follicle, as is evidenced by the fact that their centre is perforated by a hair. This petechial eruption is present in typical form in the most recent of our cases. Sometimes the eruption appears in the form of blood-containing vesicles, which may be of such large size as to resemble the form of skin disease called pemphigus. The vesicle may rupture and its base ulcerate. Sometimes there may be large subcutaneous extravasations of blood. These eruptions, if such they may be called, are most common in the lower extremities, a fact exemplified in all three cases. In cases I and II there are considerable swelling and tenderness of both legs, which are covered with large bruise-like patches of extravasation. The largest patch is on the anterior surface of the right tibia and is several inches in length. It is of a deep purple color, and over it the epidermis is thick and desquamating. Extravasations into the connective tissue and muscles may give rise to great pain, swelling and loss of movement in the affected limb, generally one of the lower extremities. The calf of the leg, the popliteal space and the loose connective tissue around the tendo Achillis, are favorite sites of these extravasations, but the muscles of the thigh and trunk, such as the recti abdominis and the pectorales, may be attacked.

The swellings may be at first soft, later, of a board-like hardness. The skin covering them sometimes inflames and suppurates, giving exit to grumous blood, and leaving behind an ulcerating cavity. Hemorrhage in other situations is quite common, especially in the form of epistaxis, which may be of daily or nightly occurrence. In case I epistaxis occurred every night. Hemorrhages from the bowels may be spontaneous, but are more apt to follow the administration of purgatives. Hæmaturia sometimes occurs.

The effusion of pleurisy or pericarditis in a scorbutic individual, will certainly be hemorrhagic. More than a month ago I exhibited in this room a patient from whose left pleural cavity I removed twenty-two ounces of hemorrhagic effusion. I said at the time that, in my opinion, a sanguinolent pleural effusion was not so much an indication of tuberculosis of the pleura as of a scorbutic diathesis. This patient has since died, and at the autopsy, no tubercle was found in either lungs or pleura.

In severe cases the bones may be affected in various ways. Either spontaneously or as the result of slight injuries which, in a normal constitution, would be followed by no such effect, extravasations of blood take place beneath the periosteum which, if extensive, may lead to partial necrosis of the underlying bone. The tibia is the bone most frequently affected in this way, doubtless on account of its exposed situation. Sometimes the epiphysis of a bone is separated from its attachment to the shaft, by the extravasation of blood between the two portions. This is most frequently observed in the ribs at their point of junction with the costal cartilages. The first symptom of this complication is a painful and tender swelling at the point of junction of rib and cartilage, followed by abnormal mobility and crepitation of the affected spot. Several ribs on either side may be affected in this manner, the result of which may be that the sternum, deprived of its usual supports, sinks inward toward the spine. It is said that reunion of the separated portions will occur in case of recovery; but when the disease is accompanied with such changes as these, it generally ends fatally.

The callus uniting recent, or even very old fractures, is apt to soften in well-marked cases of scurvy. Inflammatory hemorrhagic effusions into the joints, especially of the knee and ankle, have been observed and are known as scorbutic arthritis.

A peculiar affection of vision, a form of amblyopia known as hemeralopia, has been observed in a number of cases. By hemeralopia is meant an inability to see distinctly except in a bright light. Another name for the affection is night-blindness. It has been most frequently observed in sailors who have been long exposed to the glare of a tropical sun while suffering from scurvy or greatly debilitated from an improper supply of food. It is said that the ophthalmoscopic examination of such cases does not yield any positive results. The disorder of vision is doubtless caused by exhaustion of the retina, which, in order to perform its function, requires the stimulus of a strong light.

Although probably no case of scurvy runs its course without abnormal rise of the body temperature, fever is not an essential feature of the disease, but is secondary to the inflammatory complications of gums, skin, connective tissue, bones, joints, etc. In all three cases the temperature has been above the normal, and in one it was 103° at the time of admission.

The origin of this disease has naturally been sought in the blood, but thus far no definite change has been detected in the composition of this fluid; that is, no change not met with in other forms of anæmia not attended with scurvy. The conclusions of chemists with reference to the composition of the blood are diametrically opposite. Thus one set of chemists has demonstrated an increase of the salts of the serum, especially the chloride of sodium, to double the normal amount, while another has been able to prove that they are diminished. A more definite result, certainly none could be more indefinite, might be reached by the analysis of the solid tissues, especially the blood-vessels, connective tissue and muscles.

Treatment.—If diseases were divided into preventable and non-preventable, scurvy would certainly head the list of the former, for there is none concerning the prophylaxis of which we have more certain rules. Without entering into particulars, which may be readily inferred from what I have said of the causes of this disease, it may be asserted that scurvy will never make its appearance, either in laboring or idle men, who are supplied with plenty of nutritious food. From an anti-scorbutic standpoint no single article of food can be compared with the potato. In the treatment of the disease itself, immediate attention should be paid to the gums; for until they are in a comparatively healthy state, the first two steps in the digestion of solid food, mastication and insalivation, cannot be taken. While life may be supported indefinitely by milk, eggs and soup, such life

is not one of hard work. Solid food is the prerequisite of solid work.

Gargles of solutions of potassium chloride and tincture of myrrh will be found of service; also, painting the gums with strong solutions of nitrate of silver, or with the solid stick. The strong fetor of the breath may be corrected by adding carbolic acid to the mouth wash. Two or three grains to the ounce will be sufficient. Internally, lemon juice should be administered. One of our patients has greatly improved while consuming six lemons daily. If iron is tolerated, it may be administered in the form of Blaud's pill, which contains potassium as well as iron.

PELVIC ABSCESSES AND THEIR DIFFERENTIAL DIAGNOSIS.

BY ARPAD G. GERSTER, M. D.,
PROFESSOR OF SURGERY IN THE NEW YORK POLYCLINIC, ETC.

Pelvic Abscess; Differential Diagnosis.

GENTLEMEN:—The patient before you, a man about thirty-three years of age, has an extensive pelvic swelling located to the inner aspect of the os ilium on the right side. It was preceded by a sickness which the patient called lumbago, and also by lead poisoning which caused considerable intestinal trouble. The doctor who brought the patient says he punctured the fluctuating swelling and found pus. Therefore, the answer to the question as to the character of the swelling seems to be clear that it is an abscess. As the swelling developed gradually, it is probably a cold abscess.

Before proceeding to the question of treatment, we will have to find out if possible the cause of the abscess. First of all, we may have to deal with a perityphlitic abscess. The patient has had bowel trouble accompanying lead colic. The cæcum is one of the parts involved in lead colic, and one of the most constant symptoms is constipation. This patient has been constipated. There may, then, have been an enteritis at the cæcum, an enteritis which extended to the vermiform appendix, and which lead to agglutination, perforation, and the formation of an abscess in the right groin. This may have worked its way in the usual manner, raising up the peritoneum until it came beneath the transversalis fascia and the skin where it now is. It was at first, according to all appearances, a retro-peritoneal abscess.

Another possibility in the case is spinal trouble. He has suffered from what he calls lumbago; it may be therefore that the abscess has had its origin on the lower portion of the spine, or on the sacrum. Cold abscesses forming there sometimes work their way exactly as do retro-peritoneal abscesses and appear above Poupart's ligament beneath the skin.

A third possibility is disease of the right kidney, a perinephritic abscess, for the pus in these cases occasionally, but not as a rule, works its way beneath the peritoneum until it reaches the integument above Poupart's ligament. These abscesses generally point in the loin, but while that is the rule there are exceptions which should be noted, just as exceptions to the rule that perityphlitic abscesses point above Poupart's ligament are occasionally seen. I had such a case a short time ago, in which the question was not decided until after the operation whether the abscess was perinephritic or perityphlitic. It had pointed in the loin. After the operation it became clear that the case was one of perityphlitic abscess; there was nothing abnormal about the kidneys.

We shall have to carefully examine this patient to determine whether he has kidney trouble, spinal or pelvic trouble, or intestinal trouble as the cause of this abscess.

When asked to state where he felt his lumbago the man indicates the junction of the sacrum and os ilium on each side. He favors the right leg in walking. The further fact that the pain ran around both sides and shot down into the thighs would lead us to suppose that the original trouble was near the median line—that the affection developed in the centre of the posterior aspect of the spine or pelvis.

The swelling, as you see, is located just above Poupart's ligament on the right side, and fills the entire iliac fossa. When the patient flexes the legs and the thighs I can make deep pressure, and find that the swelling extends to the median line. It is very large, and is distinctly fluctuating. We have to deal with a much larger abscess than the outer appearances would indicate. The loin itself is empty. If we had to do with kidney trouble I believe there would be distinct swelling in the right loin. His water, he says, has always been clear, and that which he has passed to-day is normal. So far as it goes that is evidence that there is no kidney trouble. We may regard the question as having resolved itself into two: a question of pelvic abscess due to spinal or pelvic disease, or one due to perityphlitis.

The patient says he has had the pain which he attributes to lumbago for four or five months. It is, therefore, a chronic affair. His general condition has become lowered.

If we can find some physical signs of pulmonary trouble it will go toward confirming the view that he has tubercular disease of the bones of the pelvis, probably of the os sacrum.

The patient says that he had pleurisy two years ago. This is a strong link in the chain of evidence. I am going through the evidence with you methodically to demonstrate how to arrive at a diagnosis. I do not simply diagnosticate pelvic abscess. That is not sufficient. We must be more precise in diagnosis if we would be of some use to the patient. The doctor who would have examined that abscess alone and not the internal organs also would not have earned his fee. If you want to treat your patient successfully, you must know *all* that you have to treat. If you do not know the original cause of the trouble, your treatment will be mere haphazard, chance work.

As you see, this man's chest is not symmetrical. There is a sinking in on the right side. There is distinct dulness in the axillary line corresponding to the base of the right lung, both anteriorly and posteriorly. The respiratory sounds at the base of the right lung are diminished. It can not be pronounced normal vesicular breathing. There is slightly bronchial breathing at the right apex.

I would diagnosticate induration of the right lung, old deposit of pseudo membrane of tuberculous nature around the base of the right lung. And I would also diagnosticate a cold pelvic abscess dependent upon trouble in the sacrum or lower portion of the lumbar spine. Still I would make a reservation in the diagnosis, as there is a possibility which can not be absolutely excluded. If this man had not told us that he has had lead poisoning and lead colic I should have made this diagnosis without any reservation. But having been told that he had trouble with the gut, I would not exclude absolutely, and without any reservation, the possibility of perityphlitic abscess, although the chances of its being such are very slight indeed. Perityphlitic abscess sets in with an acute attack which resembles peritonitis. In almost all instances it begins with abdominal distress, very acute pain, and a rapid development of a tumor in the groin.

Here is a large pelvic abscess. Is it proper in a case of this kind to drain the abscess? that is the question. If I had the patient in care at a hospital where there were all the guarantees of a careful and competent management of the wound, after the incision had been made, I possibly would do the operation, because if the abscess were incised and drained, the chances would be that the walls would afterward collapse, come in contact again, a sinus would be left which could be kept sweet by proper dressings, and the man would be enabled to go about with comfort. But I confess that I do not like, without urgent indication, to open large abscesses which have their origin in disease of the spine or pelvis. When the Listerian treatment first arose its author laid great stress on the statement that these cold abscesses, originating in hip-joint disease of the spine or pelvis, etc., could be incised without danger, and that the teaching of old-time surgeons not to meddle with cold abscesses was no longer valid. For a time we all believed with Lister, but we have again come to modify that view. We have come to say that such abscesses should be incised only for some urgent indication; for instance, on account of their great size, impeding locomotion. I have seen such abscesses swell up the thigh six or eight times its normal volume, filling out the gluteal and adductor region so that the patient actually could not walk. In such cases, of course, an incision would be proper. In other instances, the abscess may threaten to perforate in the vicinity of the anus, which would be very unfavorable since the fæces would be likely to infect the abscess cavity.

There may be other urgent indications for the incision of a cold abscess. We have seen a case here in which the pain was so acute that the patient sought the counsel of the neurologist who treated him for sciatica. When he was turned over to us we found a cold abscess, which had been working its way out of the pelvis, through the greater sciatic notch. Then we knew that the patient did not need the treatment of the neurologist, but rather of the surgeon. In this case we would evacuate the abscess on account of the great pain it is causing.

Shall we evacuate the abscess in this instance by incision or by another method, which, although not perfect, is a very good substitute for incision? If you incise the abscess, it cannot heal until the disease causing it has healed. The causal lesion, however, is not likely to heal very rapidly, therefore it is to be presumed that the fistula will remain patent and the discharge will continue for a very long time; and if you want the fistula to remain in good condition it will be necessary to keep it dressed antiseptically all the time. If you should leave off the dressings, or allow the patient to manage the wound himself, you might be sure of sep-

tic material extending through the fistula up to the original trouble, whether in the spine or in the pelvis. That should be avoided by all means. Free incision and drainage by a tube would necessitate your constant care of the fistula until it closed. If you cannot make up your mind to the second part of this duty you should not choose the first. If you incise the abscess you thereby put yourself under obligation to the patient to care for the fistula afterward. It will not do to cut open the abscess and let the patient shift for himself, or turn him over to somebody else; for on you rests most of the responsibility for everything that happens subsequently.

Cold abscesses are divided into two classes, those which are becoming larger and in which there is a continuation of the disease from which they originated, and residual abscesses, or those which have remained after the bone disease which caused them has healed.

In the latter class of cases, although the bone disease has healed, there may remain in the abscess cavity some bone detritus to retard the absorption of the pus and union of the walls. No new pus, however, is thrown into the cavity, the old pus corpuscles undergo a peculiar disintegration, the contents of the cavity become ropy, and are tinged a reddish color. Furthermore this ropy serum shows a peculiar glitter in reflected light. If you examine some of the contents of the residual abscess under the microscope you will detect numerous little cholesterin crystals as the cause of this glitter. If you empty the cavity you will find that it will not refill, for the cause of the abscess, he disease in which it originated, has been cured. I had such a case in a man who had a swelling occupying the adductor region of the thigh. Having been present nearly twelve years, I was led, as well as several other surgeons, to make the diagnosis of cystic growth. But when I came to operate I could not find the cyst sac; the walls consisted of the muscles and fascia surrounding the swelling. I then cut into the cavity, evacuated a large quantity of material like that just described, inserted my finger and found a sequestrum of bone which was found to have been cast off from the lesser trochanter. The man then remembered that many years before he had had some trouble in the trochanteric region which was accompanied by high fever, and which confined him to the bed. The sequestrum was less than half an inch in its longest diameter, was rounded off on one side and rough on the other, and corresponded to a notch in the lesser trochanter. In a case of that kind, of residual abscess, you need not hesitate to evacuate the contents, for the bone disease having healed, the cavity will not refill, and the walls will close. But if the bone disease remain and you make an incision and drain the abscess cavity, it will go on to discharge pus, infection may take place through mismanagement, the bone disease may extend, the patient become hectic, and, although he may have been doing fairly well before you incised the cold abscess, he may rapidly succumb to the additional inflammation which your incision gave rise to. Therefore I repeat, do not be too rash in interfering with cold abscesses.

In this case I would advise the patient to go to the hospital, where he will be kept in bed a week or ten days; then we shall disinfect the parts thoroughly, plunge a large-sized trocar into the abscess cavity, allow as much of the contents to escape as will, guarding at the same time against the entrance of air into the cavity, and possible infection; then inject a certain quantity of iodoform after Verneuil's method which you have seen me adopt on several occasions. The fluid consists of a solution of five parts of iodoform in one hundred parts of ether, or the emulsion recommended by German authors, consisting of a similar proportion of iodoform and glycerine. The latter can be used in larger quantity than the former, as the injection of a large quantity of ether into an abscess might produce serious ether intoxication.

After the abscess cavity has been injected with this emulsion it will gradually refill again, and possibly a second time, but if the injection be repeated the contents will finally become a clear, limpid fluid, which has no resemblance to pus. The refilling becomes slower and slower, and the patient derives a great deal of comfort from the procedure. I think the healing of the primary cause of the abscess may also thus be hastened, especially if the iodoform could reach the site of the bone disease.

Were the cause of the abscess situated in an accessible region the surgical treatment would be different. In that event I would slit open the whole abscess and scrape out all the tuberculous lining with a sharp spoon. Then I would search for the fistula leading down to the bone (supposing that the pelvis was diseased near the crest of the ilium), I would lay it open, and remove with the chisel and mallet all the diseased bone, and then close the wound as a freshly made clean wound, and I would expect primary union and healing after the one operation. If you

have to deal with tuberculous bone in *accessible* portions of the body, remove the diseased portion of bone at the same time when you open the abscess, and rapid cure will follow. But if the tuberculous affection be *inaccessible*, you should be careful about interfering with the cold abscess to which it gives rise. Those of you who received your surgical training twenty-five years ago, as I did, have found that the old time surgeons knew very well whereof they spoke when they gave the injunction not to meddle with cold abscesses. They could not explain why it was dangerous to incise cold abscesses, but there was common sense and good observation at the bottom of their teaching, and although for a time the rule which they had established was seemingly invalidated, yet we see it again re-established to a great extent. And so it is with many other things which seem for a time to be overthrown by new truth; at last we have to go back and admit that the grain of gold contained in old teachings must not be thrown away with what is evidently but rubbish.

Communications.

ADDRESS IN MENTAL DISORDERS.[1]

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When primeval man by means of his split flints had so subdued the opposing forces of nature that he had leisure to think of things other than the immediate supplying of his wants, his attention was, no doubt, most painfully arrested by the torments of sickness. In that hour was born that science, which in the lapse of ages has developed, until now it constitutes the vast mass of discovered fact, established deduction and bold speculation which we know as the science of medicine. At first, the outward manifestations which were called symptoms attracted the observer. Ages probably passed by before these symptoms were in the consciousness of the race associated into well defined groups. Then the underlying causes began to be sought out. Morbid processes were investigated, and so step by step the study progressed until at present, pathology has so far been perfected that most disease-processes are understood, and when we speak of typhoid fever or any other equally well-known affection we refer not to a group of symptoms but to a definite disease-process. In mental medicine the pathological problems are so recondite that hitherto they have in great part baffled investigation; it is indeed an open question how far we shall ever be able to apprehend the minute structural changes which are connected with morbid mental action; there are problems in the settlement of which our finest microscopes are mere blundering, useless tools. To our utmost study the human spermatozoa are nothing but irregular, transparent specks of protoplasm not to be distinguished one from the other. Yet the records of past generations are written in those formless particles, and in them also are enfolded the potentialities of future successions of men. From one shall come forth a demon, from the other a saviour of the race. Who shall solve the riddle of their construction? Helpless and hopeless are we. Almost hopeless is it that we shall ever understand the infinitely delicate changes which take place in the complex protoplasm of nerve cells, and be able to see the waves of emotional and mental excitement or paralysis which sweep over the individual, or to recognize the alterations in nervous protoplasm gone mad. Or our so-called mental diseases are simply groups of symptoms, which may, for ought we know, in different cases arise from essentially different pathological processes. In one individual suffering from paralytic dementia the depression of melancholy clouds the life, whilst another man with apparently the same brain lesion revels in the wild exaltation of the mania of grandeur.

For the purposes of discussion, we must at the present stage of our knowledge of insanity, give names to certain symptom-groups, but for the purpose of clear thinking it is essential for us to remember that these symptom-groups are not diseases, but associated symptoms which may in different cases depend on essentially different causes. Is a melancholia which is produced by impacted fæces and relieved almost at once by the clearing out of the rectum (*Amer. Journ. of Insanity*, XLII, p. 264), the same disease as a melancholia depending upon hidden and irremovable causes in the nerve centres? It is odd that alienists of wide culture and ability have hot disagreements in regard to the diagnosis of a case. Thus in a review of Professor Seguin's Opera Minora, Dr. Kiernan, of Chicago, exclaims of a case reported by Seguin as a maniac, "whatever the psychosis might have been it certainly was not mania." If mania were a distinct

[1] Delivered at the meeting of the Pennsylvania State Medical Society, June 7, 1888.

disease it is hardly likely that a neurologist of the experience and culture of Dr. Seguin would not be able to recognize it. If mania be not a distinct disease, but a mere set of symptoms, surely the vehement assertion made by Kiernan is little less than an absurdity. The truth is that the thought of modern alienology is pervaded by the fallacy that our symptom-groups are diseases.

Symptomatology in any department of medicine is a study of the first importance, but in mental medicine it at present almost bounds our horizon. To the study of this symptomatology men are urged not only by the needs of the insane but also by the neces sities of the sane.

If there be one thought more than another which ought not to be forgotten, it is that the human mind diseased is the human mind still. The coming on of insanity marks not the appearance of a new entity or a new force. The old entity or the old force simply goes astray. It is the failure to grasp this clearly which has lead many a lawyer to say to the expert: "You crazy doctors believe that everybody is insane," and has occasionally betrayed the unwary alienist into acknowledging that this assertion is true. I say distinctly that it is not true. Sanity is the condition of the great bulk of mankind, but the impulse, the mood, the failure of judgment, the lack of coherent thought—the various symptoms which constitute the chaos of disturbed intellection find their counterparts, or rather their germs, in every healthy mind. So long as these impulses, moods, etc., can be dominated by the will of the individual, just so long are they simply the weaknesses of humanity; but when the will of the individual is powerless before them, then is that individual insane. The passage from one state to the other may be so gradual that only to omniscience is it possible to say when the line between sanity and insanity, responsibility and irresponsibility is crossed.

Insanity so terribly affects the relations of men that it very frequently is the centre of the legal battles whose arena is our courts. Not rarely the keenest and most thoroughly trained intellect is baffled in attempting to decide how far responsibility should attach to the alleged criminal, or how far the original will of the individual has entered into the instrument which purports to be his last will and testament. When this is remembered, how utterly absurd appears to be our system for deciding the mental condition—a system which we have inherited from the times of oppression and of violence. Twelve men, perchance honest, of a certainty, many of them uneducated, and probably all of them ignorant even of the ordinary principles of medicine or of mental action; one judge, learned in the law, and bound in the iron hoops of legal prejudice and legal methods of thought, unacquainted with the science of medicine, and mayhap with the laws of mental action; two lawyers, sharp, trained in every device for brow-beating and baffling witnesses and in every crafty method of hiding the truth and of misleading the ignorant, contending one with the other; experts, chosen without guarantee of their knowledge of the subject, hired by one side or the other, possibly dishonest, certainly liable to have their view of the case affected by the glass through which they have looked at it. This is the machinery which in theory is to perpetuate justice, but which in truth in a large proportion, if not the majority of cases, works out the wrong. With such a system and such a method is it a wonder that the decisions of our courts in questions of insanity are a laughing stock among those who know? Is it a wonder that the sane man is so often judged insane, while the lunatic almost as often has the stamp of sanity put upon his untoward acts?

Is it a wonder that those who have seen much of this so-called justice grow cynical and look upon legal procedures as farces which, alas, but too often end in tragedies? Not many years since two lawyers of eminence came into my office, and laid a certain case before me, desiring that I should go upon the stand and declare that their client was sane. After listening to their statements, I said, "This man is absolutely insane, and you cannot find on the two continents an individual who is at once honest and capable who will not give you an opinion similar to mine. There is no room for doubt in the case. If, however, you want to win, all that you must do is to call in no experts, declare that you do so because doctors and experts are fools, browbeat and confuse, as much as lies in your power the expert witnesses on the other side, and then appeal to the jury that this American citizen shall not be deprived of the rights for which the immortal Washington, Adams and Jefferson contended, and for which heroes innumerable have fought and died." They took my advice. The witnesses were confused, the jury was dazzled by the eloquent appeals. The judge made a charge which the newspapers of the day lauded to the skies, but which seemed to me veritable foolishness, and the man was declared sane. Shortly afterwards, in the wreck of his intellectual power, he had still sense enough to perceive that in

order to protect himself from himself the restraints of an insane asylum were essential, and I believe that he is still a voluntary inmate of such an institution.

To the truculent barons that gathered around King John at Runnymede, personal liberty seemed the one point for whose preservation all law should exist. But times, although not laws, have changed, and to-day the danger to the State is not that personal liberty shall be restrained, but that it shall degenerate into license. The spirit of the barons still lives in our legislation and in our public opinion in regard to insanity. Pamphlets, newspapers, lunacy commission reports, all portray the hardships of depriving the lunatic of his freedom, and men grow eloquent concerning the danger lest sane men shall be shut up in asylums. The medical profession seems to be in the eyes of the public an avaricious monster lending itself for gold to any nefarious design. Laws have for their basis the idea that men and women are for criminal purposes habitually incarcerated in asylums. The fear of this is, however, to my thinking but a survival of mediæval feelings and mediæval possibilities. It is now nearly twenty years since I began to study insanity as a specialty, and I have never yet known a case in which a person was improperly placed in an asylum, though I have known cases in which persons whom I believe to be lunatics have been set free by lunacy commissions. More than this, I have had personal knowledge of almost every kind of prejudice as the result of the failure of the law to give protection *from* the lunatic. I have known the prisoner whose craziness should have been recognized allowed in his cell weapon and opportunity for mashing out without cause the brains of an unsuspecting keeper—an almost raving lunatic suffered to pour sulphuric acid upon his victim—a mother permitted to cut the throat of her own offspring and to die by her own hand; beside them, a father scarcely stopped by neighbors in time to prevent the final completion of rape upon his daughter—another father allowed to blow out the brains of the helpless little child kneeling before him in an agony of prayer for life. I might extend the catalogue, but I forbear. Waste of property, dishonor, death by murder and suicide—these constitute a long line of perpetually repeated tragedies which might and which ought to have been prevented by early recognition of the mental condition and sequestration of the insane criminal. On the one side, the lunatic himself and his insane victims call aloud for protection from the wild-beast like fury of the maddened brain. On the other is the bugbear of personal freedom. Let, however, a crime be committed, and here, at least in Pennsylvania, that law which has made protection so difficult, cries for blood, although punishment has very little deterring effect upon the insane, and the only protection which is afforded to the community by hanging the insane murderer is a protection from his individual acts. A dead lunatic is certainly a harmless lunatic. The Pennsylvania law is wise in that it does give the judge the right to perpetually incarcerate the lunatic who has once been acquitted on account of his lunacy. But the general workings of the modern law is shown in the case of B. recorded in a recent number of the *American Journal of Insanity*. This man was a moral imbecile driven by a furious impulse to torture and kill, whose greatest pleasure was to tie up horses in the woods and gradually whittle them to death, to mutilate living cats, torture chickens, break the legs and tear to pieces, whilst living, small birds, and who, when opportunity offered reached the very heaven of his joy by assaulting, torturing, killing human beings. When twelve years old he took his toddling brother into the woods and nearly flogged him to death. He attempted to strangle a younger brother and to smother his infant sister; had stabbed various people, essayed to suffocate a harmless imbecile, and to choke another inmate of the asylum, and committed at least two criminal assaults on women, the last during an escape from the asylum. Tried for this last offense in spite of the efforts of alienists, the patient was convicted and condemned to six months' imprisonment. His conviction of course was tantamount to a legal declaration of sanity, and the judge in sentencing the prisoner told him that at the end of the three months he would be a free man.

The problems growing out of the relation of insanity to crime are exceedingly difficult, and I do not propose to-day to say more about them except to express my conviction that the present system of trial would be improved by the presence of an alienist upon the bench as an associate judge, or by the reference of the question of insanity in criminal, as well as in civil cases to a commission, whose report might probably be subject to review by the judge.

Possibly, the public opinion which at present demands the hanging of insane people is not so far wrong as some of us think, but certainly there can be no question as to the evils which have resulted from the systems

of civil insane commissions. As proof of this I shall cite two recent cases which I believe have not been before published, and in which I have been personally concerned. The first case is that of Dr. Martin Weaver, an elderly gentleman living at Germantown. The petition asking that Dr. Martin Weaver should be declared a lunatic was filed by his nephew, but the circumstances were such that the pecuniary interests of his daughter, Miss Weaver, were chiefly involved in the declaration that her father was a lunatic.

Twelve witnesses in all, including the party who served the notices were examined on behalf of the petitioner, and but two or three of these witnesses testified to any knowledge of the alleged lunatic during the three years preceding the inquisition. On the other hand, twenty-two witnesses testified in the most positive manner as to the sanity of Dr. Martin Weaver covering a period from his boyhood to his present advanced age of eighty-one years. The following well-known physicians affirmed without qualification the undoubted mental capacity of Dr. Weaver, after they had made a personal examination of him: Dr. D. Hayes Agnew, Thomas G. Morton, Dr. John B. Chapin of the Pennsylvania Hospital for the Insane, Dr. John C. Hall of the Friend's Insane Asylum, Dr. Henry M. Wetherill of the Pennsylvania Hospital for the Insane, Dr. Charles K. Mills, and Dr. J. R. Landis, the family physician of Dr. Martin Weaver for the past six consecutive years. Further, no less than eight well-known lawyers testified from personal knowledge as to the entire ability of Dr. Martin Weaver and his capacity to manage his own business. Not a single physician or expert on insanity was called to testify that Dr. Martin Weaver was insane. Nevertheless, the jury decided Dr. Martin Weaver to be insane in the face of the strongest protest from the commissioner, who was acting as judge in the case. The court of common pleas after hearing the whole case set aside the report of the jury as contrary to the evidence, but when the matter was carried to the Supreme Court of Pennsylvania, it was then decided that the common pleas court had not the power to set aside the verdict, which still stands. I have myself in two long interviews studied the mental condition of Dr. Weaver, and although he is *de jure* a lunatic, he is *de facto* sane.

Living near by to Dr. Martin Weaver was an adult imbecile man, whose father died after a long period of chronic lunacy. Miss Bessie Weaver, the same woman who was involved in the previous suit, was married to this young man in the city of Camden, and suit was afterwards brought in order to have the marriage set aside on the plea of the imbecility of the man. —— was afterwards examined by Dr. Chase, of the Norristown Asylum, and myself, and we pronounced him without hesitation an imbecile of a low grade. Without going into the details of our examination, it suffices for the present to state that, I questioned him to discover whether the marriage had been consummated or not, but did not succeed in making him clearly understand what I meant, although I judge that there had been no consummation of the marriage. Although he had been sent to school until he was twenty-two or twenty-three years of age, he was unable to give change for a dollar without counting on his fingers, and in no way could he completely give the change for a two dollar bill. He was without doubt a harmless, docile imbecile, yielding like putty to any one that he would come in contact with; yet the jury was divided, about half of them declaring that he was able not only to take care of himself, but his inherited estates, which amounted to some hundreds of thousands of dollars. In the absence of any agreement he remained in the eyes of the law sane, and I am informed that this case was settled by the payment of a large sum to Miss Weaver, never to come near the imbecile. I understand Miss W. has a very high opinion of our legal methods.

The law of Pennsylvania provides two methods of declaring a patient insane by civil process. Thus one act requires that on statement in writing of any respectable person that a certain person is insane, and that the welfare of himself or of others requires his restraint, it shall be the duty of the judge to appoint immediately a commission which shall inquire into and report the facts of the case. This commission shall be composed of three persons, one of whom at least shall be a physician, and another a lawyer. In their inquisition they shall hear such as may touch the merits of the case, as well as the party complained of or his counsel. If in their opinion it is a suitable case for conviction the judge shall issue his warrant for such disposition of the insane person as will secure the object of the measure. According to the second act, upon the application in writing of relation by blood or marriage, or of a person interested in the estate, a commission empowering one or more persons as commissioners may be issued by the court of common pleas by virtue of which the sheriff is required to summon such number of per-

sons, not less than six nor more than twelve upon the inquest, as the circumstances of the case may seem to them to require. When this inquisition after examination has declared the person a lunatic the aggrieved person may traverse the decision, provided such traverse be fulfilled within three months after the declaration of the inquisition. The power of traverse consists of a trial before a jury in the court of common pleas to determine whether the mind of the alleged lunatic be deranged to such an extent as to disqualify him from conducting himself with perfect safety to himself and others, disposing his own affairs, and discharging his relative duty.

It so happens that I have never seen practiced the method of declaring a person insane by means of a commission of three persons as directed by the act here first spoken of, and its use must be very rare; the second plan being almost universally pursued probably because the law directly affirms that under it the estates as well as the person of the insane man pass into the hands of the trustees. This second method is practically a jury trial and possesses all the inherent faults of such a trial. It is hardly necessary to recall attention to these faults. They may be summed up as existing in the expensiveness of the method, and the absolute impossibility of obtaining just decisions in regard to intricate scientific questions, amid the ignorance and prejudice of twelve men drawn almost invariably from the lower walks of life and under the influence of trained minds trying to mislead. "Of course he ought to be confined in the asylum," says the lawyer with a sneer, "he pays them forty dollars a week," and the jaw of the juryman sets as plaster-of-Paris sets in the mould of the sculptor.

All the legislation that would be required to make the laws of Pennsylvania in regard to the civil side of insanity worthy of some respect would be to abolish the second method of declaring people insane, and to require that the decision should be allowed to rest with a commission consisting of three persons, one of whom shall be a lawyer, one a doctor, and one a general man of business. I believe myself that the decision of such a commission should be finally subject only to review by a bench of judges who, under restrictions, with which it is not necessary to here occupy time in discussion should have the power to overrule it. In insanity cases I would do away entirely with the *habeas corpus* and its accompanying jury trial. Owing, however, to its close connection with political liberties in the past, the jury is still a fetich which is worshipped probably by the bulk of the legal profession and the majority of the American public. It remains, however, a feudal relic utterly unsuited for many of the emergencies and complex relations of modern life. There is even a widespread belief that the man has a constitutional right to a jury trial. It is hardly necessary to say that this is not correct, that the constitution simply guarantees that the man shall not be deprived of his liberties without due process of law. What this process of law shall be is left to the legislature.

Perhaps, however, I am all wrong in thinking that the term administration of justice, applied to the processes of the law, ought to be considered anything more than an euphemism. Wiser, no doubt, was the dictum of a very famous lawyer which I heard publicly quoted by Mr. George Biddle with approval. According to this dictum the law does not exist for the purpose of doing justice, but for the purpose of preventing men from cutting one another's throats. That in regard to insanity, law in America is not always successful, even in the latter aspect, is shown by a case of which I have cognizance in which a jury acquitted a man of homicide on the ground of instantaneous irresistible impulse, although the murderer had armed himself, traveled nearly one hundred miles with the apparent intention of killing his wife's paramour. This case is only one of many that might be cited as an illustration of the fact that the results of a jury trial depend much more upon the sympathies of the jury than upon the justice of the cause.

I insist that not only for the purpose of justice, but for the purpose of control, the Pennsylvania law in regard to insanity still needs modification, a modification which to my thinking ought to be easy of accomplishment, because it would consist chiefly in the abrogation of an old law, which in spirit is discordant with the recent act. Let at least in all civil cases the question of sanity or insanity of an individual be decided by a properly constituted commission, and it may happen in coming decades that justice shall invade even the province of the criminal law. Is it not fitting for this association to move this matter, and would it not be well to appoint a committee who should have power to represent this body? I therefore offer this resolution:

Be it resolved that the President be directed to appoint a committee of —— members who shall confer with the State Committee of Lunacy, and if in the concurrent opinion of

the committee changes are advisable in our laws relating to lunacy, shall have power to represent this body in obtaining such legislation.

NEPHRECTOMY FOR NEW GROWTHS.[1]

BY JOHN B. DEAVER, M.D.,

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Mr. President and Gentlemen:—The two most important and common forms of new growths of the kidney are sarcoma and carcinoma; fibroma, lipoma, myxoma, angioma and adenoma are occasionally met with. Sarcoma is more common than carcinoma: carcinoma is the form of malignant disease usually met with as a congenital affection. Carcinoma is very rare in children, being more common in old age. A sarcomatous or carcinomatous kidney may grow to an enormous size; this is true especially in children. Roberts notes a case in a child of six years, in which the tumor weighed thirty-one pounds. In the growth of the tumor its tendency is to extend into the pelvis, and to frequently obstruct the ureter. Both kidneys may be the seat of malignant disease, but it is rare for both organs to be attacked at the same time. Secondary deposits are found in many of the cases that die of the disease. The renal vein often becomes involved, and through it the cancer may grow into the vena cava, thus furnishing a focus from which infarcts may be carried into the lungs and liver. Fibromata usually do not give rise to any special urinary symptoms. Wilks cites the case of a fibroma of the kidney in which hæmaturia and pain in the loins had existed for ten years, the tumor being present for six years; death was preceded by the symptoms of uræmia. Neither does lipoma, myxoma, angioma or adenoma occasion any urinary symptoms that would be indicative of either form of growth, unless they reach such a size as to occasion compression of the renal vessel or ureter, in which event the enlargement could most probably be detected, yet the nature of the growth could only be determined after its removal. The symptoms of malignant disease of the kidneys are the presence of a tumor, hæmaturia and pain. Hæmaturia occurs in fully half of these cases, being intermittent, the amount of blood lost depends upon the patient's habits and occupation. The blood sometimes forms clots in the ureter; a specimen of the urine under these circumstances will show a cast of the ureter. In the interval between the attacks of hæmaturia, the urine contains but little pus and albumin; occasionally tube casts. Fragments of cancer structure in the very rare cases in which they are said to have been found, would of course be conclusive, but the utmost caution should be exercised, recollecting the great variety of shapes and sizes assumed by the epithelium of the urinary passages. The appearance of hæmaturia depends partly on the way in which the tumor invades the kidney, and on its increase in size. If growing in such a way as to compress the ureter in the early stages, before any erosion of the mucous membrane has taken place, blood even if set free in the pelvis, cannot reach the bladder. If hæmaturia is present before any tumor can be felt, it has only a subordinate value, but if occurring after the discovery of such tumor, the combination is of the highest significance. Pain is complained of in almost all cases and is situated in the loin and abdomen, and may radiate down the front of the thigh. The presence of a tumor is a very significant symptom. Minges found a tumor absent only three times in one hundred and three cases, and in two of these, a tumor was not discovered because it was not looked for carefully. The tumor is solid, resisting to the touch, generally but slightly movable; yet I know of two cases seen by Prof. Osler in which the tumor was very movable; if the abdominal walls are thin and the tumor large, its anterior surface may be satisfactorily palpated and may be found to be irregular. It is situated in the loin, and extends backwards, filling up the lumbar hollow, then grows forward and downward. Usually the hollow in the loin is still preserved; inspection of the back therefore without palpation, is not of much assistance in making a diagnosis. Renal tumors may be diagnosed from hepatic and splenic enlargements, with which they are most likely to be confounded, by their being rounded on all sides when exposed to the fingers, and not notched or presenting a sharp edge. Hepatic tumors are flat upon percussion anteriorly, while tumors of the kidney are resonant, unless the ascending or descending colon is displaced laterally by the growth, in which event resonance could be obtained in the flank. Splenic tumors like hepatic, are flat upon percussion in front, and there is not to be detected an area of resonance between the tumor and the ribs, which is present when

[1] A paper read before the Pennsylvania State Medical Society, June 6, 1888.

the left kidney is the seat of a tumor. Renal tumors are more likely to be mistaken for tumors of the ovaries, but here the history of the case, a careful examination of the abdominal walls and an examination per vaginam and rectum will in the majority of cases enable us to make a differential diagnosis.

Before proceeding to remove a diseased kidney, it is prudent to learn, if possible, the condition of the other organ; but this is especially important when contemplating the removal of a suppurating kidney, as in these cases the disease nearly always originates in the bladder and extending upwards, is more likely to involve both organs than is the case in malignant disease of the kidney.

Many devices have been introduced with the object of determining the condition of the other kidney, but as yet, none of these is entirely satisfactory, or, I venture to say, practicable, in the male subject. In the female, by dilating the urethra; either ureter can be catheterized without much difficulty; thus we are able to obtain a specimen of the urine secreted by the opposite kidney, after examining which, we can reach a more positive conclusion. Greig Smith practices incision of the outer urethra, and dilatation of the inner urethra and neck of the bladder, in the case of the female. The additional freedom in exploring the bladder so afforded, is much greater than would be supposed.

Nephrectomy on the living subject was first performed as a premeditated operation by Gustav Simon, of Heidelberg, in April, 1869. Three different surgeons had preceded Simon in excising the human kidney; but without knowing the nature of the tumors they were removing until the operation had been completed. The first of these operations was performed in 1861, the others in 1867 and 1868. The ventral method was employed in each, and all died. Simon's case was the fourth in which nephrectomy was performed, and the first in which the lumbar method was adopted. The patient recovered. Since that time the operation has been performed a number of times.

The different operations for the removal of the kidney are lumbar nephrectomy and removal by abdominal section; the section can be made either through the linea alba or the semi-lunar line. For the removal of new growths of the kidney, the lumbar operation would only be entertained when the tumor is small. By abdominal section we have better access to the organ, and are thus better able to deal with adhesions and the pedicle; at the same time the opposite kidney can be examined. In favor of the lumbar operation is the fact that we do not wound the peritoneum, and are supposed to have better drainage; but by using the glass drainage-tubes, with the cotton rope, the drainage after abdominal section is quite as satisfactory as after the lumbar operation.

Dr. S. W. Gross's statistics up to April, 1885, show that the kidney has been removed for sarcoma thirty-three times, with fourteen recoveries and nineteen deaths, mortality 57.57 per cent. Of twenty-six operations by abdominal section, 11 recovered and fifteen died, mortality 57.69 per cent. Of seven operations by lumbar nephrectomy, three recovered and four died: 57.14 per cent. Of fourteen survivors six subsequently died, five from metastasis, one from an unknown cause, while one was living with recurrence at the end of four months; five were well at the end respectively, of 17, 22, 23, 35 months and five years. For carcinoma in fourteen cases, four recovered and ten died: 71.42 per cent. nine abdominal sections with one exception, were fatal; in one of the four lumbar operations the patient died, and three recovered; another nephrectomy, it is not known what operation was used, resulted fatally; of the four survivors, two died of secondary growths at the expiration respectively of forty-four days and two months, and the remaining two were alive at the end respectively, of two months and thirteen months. There were then fourteen recoveries from sarcoma and four from carcinoma, making a total of eighteen recoveries from operations. Of the eighteen persons, therefore, who recovered from the operations, only two can be regarded as cured; for only two, both of whom had suffered from sarcoma, were alive and well at the end of three years after the operation. For benign tumors, four nephrectomies were done, with three recoveries and one death.

On March 11, 1888, Dr. Isaac Leopold was urgently called to see Mrs. S. T., suffering with an attack of hæmaturia, when the following history was elicited: Widow, 41½ years old, married twice, no children, several abortions, the result of her own exertions; family history good. Says that six years previously in 1882, she was operated upon for a vesical calculus, and at that time her physician told her she was getting a tumor, but she refused to believe it and continued at her work. March 11, 1888, present condition: passes no urine for twenty-four hours, then passes a large amount of bloody urine containing large clots, the blood amounting to over one pint. By examina-

tion with the sound, no vesical calculus could be found, nor could any evidence of tumor of the bladder be detected; uterus and appendages normal. On examination of the abdomen, a large hard mass was found, situated anteriorly on the left side, and filling the left lumbar and inguinal, and extending into the hypogastic and umbilical regions, two inches to the left side of median line. The tumor felt hard and was slightly movable, giving no evidence of fluctuation upon percussion; the flank was absolutely flat. Tympanitic resonance in front and above the tumor. Diagnosis of malignant disease of the left kidney was made. The patient was told the nature of her trouble and, with the administration of ergot, was ordered to quit work, to rest in bed, and was further advised to have a consultation, which latter she refused. March 12, hemorrhage had ceased, urine nearly clear, containing a very small amount of organized clot, specific gravity 1022, slight trace of albumin, no tube casts, large amount of epithelium from the bladder, and some that appeared to have come from the pelvis of the ureter. Her condition continued to improve until between March 12 and April 5 the patient had a slight hemorrhage, but Dr. Leopold was not sent for, the patient controlling it herself with the ergot which the doctor had left. April 5 she had another severe hemorrhage, when Dr. Leopold was sent for and again advised a consultation, to which the patient consented, and I was asked to see her with Dr. Leopold; when I fully concurred with him as to the nature of the case and advised operation. April 7, the patient had another severe hemorrhage, passed half a pint of blood. April 8, she was removed to a private room in St. Joseph's Hospital, and after the exertion consequent upon the journey, had three small hemorrhages. April 9, Prof. Jas. Tyson saw her with Dr. Leopold and me, and fully agreed with us as to the nature of the case. The patient remained in bed, the urine continuing to show slight traces of blood, till April 13, at 1 P.M., when nephrectomy was performed.

Description of the Operation of Nephrectomy through the Abdominal Wall, anteriorly, after the manner of Langenbuch.

After the patient had been etherized, having also been subjected to the ordinary antiseptic preparation, the left kidney being the seat of the growth, an incision five (5) inches long, not extending high enough to endanger the wounding of the attachment of the diaphragm, was made through the left linea semi-lunaris; the peritoneum being reached, was opened, and a large flat sponge inserted to prevent the escape of the small intestines, after which the descending colon and the medium through which it is attached to the posterior wall of the abdominal cavity, namely, the descending meso-colon, was brought into view, when its external layer was divided to an extent corresponding in length to the wound in the abdominal wall anteriorly, thus exposing the anterior surface of the growth and giving access to the left retro-peritoneal space, which space is occupied normally by the left kidney. The object in selecting the external layer of the descending meso-colon in preference to the internal layer, is the avoidance of injuring the blood-vessels supplying the colon, thereby lessening the likelihood to necrosis of a portion of the gut. The next step in the operation was by far the most tedious, as well as difficult, namely, the breaking up of the adhesions, the growth being most intimately adherent at all points of its surface, and the exposure of the pedicle consisting of the ureter, renal artery and renal vein. In breaking up the adhesions, it required great care not to tear through the internal layer of the descending meso-colon and the inferior layer of the transverse meso-colon, which latter separates the left kidney from the spleen, both of which layers of the peritoneum were found intact at the autopsy. When the growth was freed almost up to the point of attachment to the pedicle, a stout silk ligature was thrown loosely around the pedicle, in the event that if any part of it were torn, to give immediate means to arrest any bleeding that might be the result by simply tightening the ligature. After the completion of the separation of the adhesions, the pedicle was grasped close to its attachment to the growth by a pair of Spencer Wells' pedicle forceps, and tied with a strong silk ligature *en masse* immediately beneath the forceps; the growth was cut away, then the pedicle separated below the ligature into two portions, the vein as one, the artery and ureter as the other, each of which was included in a single silk ligature. The object in separating the vessels, the artery from the vein, being to prevent the probability of the formation of an arterio-venous wound. The next step was the toilet of the peritoneum, which was made with hot distilled water, the introduction of a glass drainage-tube, the repositing of the descending colon, which during the operation was drawn toward the middle line, the rearranging of the small intestines in their proper position, as well as

the great omentum, the introduction of six (6) deep silk sutures and the dressing of the wound. The patient died twenty-four hours after the operation, never having rallied from the shock.

The autopsy, made three hours after death, showed the edges of the wound glued together, requiring quite a little force to separate them, the peritoneum healthy, the great omentum, the small intestines and the descending colon in their normal position. The stump was perfectly dry, as was also the retro-peritoneal space, there being a considerable deposit of lymph occupying this site. The right kidney slightly atrophied and fattily degenerated, otherwise normal. The heart, small and concentrically hypertrophied.

Dr. George Dock, who examined the tumor, made the following report:

Dear Doctor:—On examining the tumor referred to me by you, I find it of an irregular oval form, ten inches in length by five inches in width. The surface is smooth for the most part, of a dark red color; the consistency is firm, except at the larger end, where a soft, semi-fluctuating mass may be felt. At one end (upper and inner) is part of the pelvis of the kidney. On cutting open the tumor, part of the kidney can be seen at the end corresponding to the pelvis. Only a small part of the cortex and more than half the pyramidal substance can be recognized. The great mass of the tumor is composed of a soft, reticulated tissue, interspersed with masses of necrotic material. In the larger end is an irregular mass of clotted blood the size of an orange. The capsule is thickened in some places, and fibrous bands pass from it into the substance of the tumor. Thin sections of the tumor taken from various parts show it to be made up of large and small alveoli filled with cells. The cells have large nuclei and a large amount of clear protoplasm. Most of them are fatty degenerated. In many of the alveoli the cells along the wall have an arrangement suggesting that of the convoluted tubules of the kidney. Blood corpuscles fill the centres of many of the alveoli. The thickened parts of the capsule have the same structure as that just described, but the alveoli are smaller, and the walls are thicker. This growth passes gradually into the substance of the kidney, which shows hemorrhages into the tubules and slight fatty degeneration of the epithelium.

The growth is to be classed as a carcinoma of the medullary type, which has probably originated in the epithelium of the cortex.

Yours sincerely, GEORGE DOCK, M.D.

The conclusions at which I arrive are:

First. Sarcoma of the kidney in children contra-indicates operation.

Second. Sarcoma of the kidney in the adult is a justifiable cause for operation.

Third. Carcinoma of the kidney in the adult, unless coming under the surgeon's notice very early, contraindicates operation.

Fourth. Malignant growths of the kidney in the majority of cases should be removed by abdominal section, after the manner of Langenbuch.

Fifth. Benign growths of the kidney are cases for the lumbar operation, but when too large to be delivered *en masse*, should be removed in sections, the precaution being taken to ligature the pedicle before cutting away a section of the tumor.

It is probable, states Morris, that renal sarcoma in children, as also cancer at any period of life, will by future experience be excluded from the category of "cases for nephrectomy" performed by any method. In cancerous tumors it is not likely that life can be greatly prolonged, unless in the exceptional case in which the disease is detected before it has long existed, or has affected the lymphatic system.

CASE OF ELEVEN COMPOUND FRACTURES, WITH COMPOUND DISLOCATION OF SHOULDER; COMPLETE RECOVERY.

BY D. BENJAMIN, M.D.,
SURGEON TO COOPER HOSPITAL, CAMDEN, N. J.

J. M., 32 years old, a large, well-built white brakeman on a railroad, fell under a freight car on the night of December 7, 1886. Examination thirty minutes after the accident showed a compound fracture of the first phalanx of the thumb, of the first, second, third and fourth metacarpal bones, and of the first phalanges of the first, second, third and fourth fingers of the right hand; also a compound fracture of the left humerus in the upper third, and a compound dislocation of the head of the left humerus, and a simple fracture of the left clavicle. The left lung was contused (bloody expectoration), and there was great contusion of the left upper part of thorax, front and back. The watch which was found in the man's left vest pocket had its case and works smashed, indicating that the left side had been severely compressed.

The patient was taken home, and his wounds were dressed and the fractures all reduced, after which he was kept perfectly

quiet on his back upon a mattress. The left arm and shoulder were treated with paste-board external and internal splints with shoulder-cap. The circulation in the right hand and fingers was so poor, from local injuries to the blood-vessels, that a bandage could not be applied sufficiently tight to keep the fractures reduced, without imminent danger of mortification of the fingers, and of a large portion of the hand. The hand was treated on a large, flat board splint (not paste-board); a large piece of oakum was placed in the palm of the hand, and the fingers were left flexed, owing to the fact that straightening them increased tension on the parts and interfered with the circulation, and would necessitate more pressure from the bandage to hold them in place. All the open wounds were closed with sutures, the wounds washed with carbolized oil, and patent-lint dressing applied. During the first week the patient's temperature reached 101°, his pulse 118; crepitation developed in his left lung, and he was troubled with cough and slight spitting of blood. After the eighth day the temperature and pulse gradually declined, and became normal about the fifth week. The wounds were disturbed as little as possible; but considerable suppuration about the left shoulder joint compelled frequent cleansing about that part.

The medical treatment consisted the first few days of anodynes and diaphoretics, and afterwards of an occasional saline cathartic and Basham's mixture. The patient was able to sit up by the latter part of the second month, and made a complete recovery with the exception of a slight deformity of the first metacarpal bone of the right hand, which, however, gives him no inconvenience.

He is now employed as a piano mover, and has perfect use of both arms.

—A rare example of patent ductus arteriosus in a woman, thirty-six years old, was shown by Dr. H. M. Murray at a recent meeting of the Pathological Society of London. The cause of death was ulcerative endocarditis, and during her life the patient was neither cyanosed nor affected with clubbing of the fingers. The ductus was three-eighths of an inch long, and admitted a quill; vegetations in large quantity existed near its opening into the pulmonary artery, into which, however, blood passed, as was shown by the presence of a distinct thrill and murmur during life. —*Medical Press and Circular*, May 9, 1888.

Society Reports.

PENNSYLVANIA STATE MEDICAL SOCIETY.

THIRTY-NINTH ANNUAL SESSION, AT PHILADELPHIA, JUNE 5, 6, 7, 8, 1888.

Second Day, Wednesday, June 6.

MORNING SESSION.

After the announcement of the delegates who had been selected as members of the Nominating Committee,

Dr. R. J. Levis, of Philadelphia, delivered the

President's Address,

on "The Traditional Errors of Surgery." After tracing recent history of the science he declared that hope might be entertained that the millennium of the art would soon arrive. The advance in late years had been in rapid ratio compared with that of the knowledge gained in the past. Error had been to a very great degree promoted by prejudice, he said, and too much teaching had been accepted from the Old World. This was done even at the present time, when American science in general surgery is equal to or in advance of that of any other nation. One error calling for immediate correction was the use in some colleges of English text-books in preference to those of American writers, when the latter are in many respects far superior to those of foreign authors.

He advocated the antiseptic treatment recommended by Sir Joseph Lister. In the general adoption of antiseptic treatment he gave credit to the younger men of the profession, whom he characterized as the pioneers in the movement. The only benefit in traditional errors is that they may lead to the discovery of important remedies and bring reform and truth.

Dr. R. Lowry Sibbet, of Carlisle, read a paper entitled:

A Brief Review of the Decisions of the Courts concerning the Registration Act of 1881.

He reviewed the decisions of the different courts in administering the Registration act of 1881. In summing up he said that the great trouble was too much registration, and asserted that the prothonotaries were responsible for this, and that if the act was intelligently executed a rapid decrease of fraud would result. He warmly advocated the appointment of a State Board of Medical Examiners.

Dr. John H. Packard, of Philadelphia, followed with a paper entitled:

The Proposed State Board of Medical Examiners.

He objected to the appointment of a State Board of Examiners, because it would put the homœopathic and other schools of the profession on an equal footing with the regular school.

Considerable discussion followed the reading of these papers, most of it being favorable to the idea of having licenses to practice issued only by a State Board of Examiners. Incidentally, the resolutions in the report read at Tuesday's session, by Dr. Jackson, were brought forward, but they did not come to a vote because parliamentary law prevented their consideration until after the scientific discussions were concluded.

The next paper was one by Dr. L. F. Flick, of Philadelphia, on

Contagiousness of Phthisis.

In this paper Dr. Flick stated, as the result of a careful and prolonged study of the appearance and distribution of phthisis in the fifth ward, in Philadelphia, his conviction that phthisis is a contagious and infectious disease.

In the discussion which followed, Dr. O. G. Given, of the Carlisle Indian School, spoke of the errors to be found in many of the statistics in regard to phthisis among the Indians, and denied that the frequency and fatality of phthisis is increasing among pure-blooded Indians.

Dr. F. P. Henry, of Philadelphia, pointed out the erroneous conclusions to which one might be led who assumed a causal relation between things which were merely associated. He instanced syphilis which is very common among sailors, who spend most of their time at sea and on ships; from which, he said, it would not be safe to deduce the proposition that syphilis is caused by sea-air and infects ships.

Dr. E. T. Bruen, of Philadelphia, said that he thought that there was much to be said in favor of the opinion that phthisis is contagious to a certain extent. The results of pathological experiment and clinical experience will, he thinks, convince one who studies the subject carefully that there is more in this theory than would appear at first sight.

Dr. T. J. Mays, of Philadelphia, followed with an elaborate and thoughtful review of many of the points raised by Dr. Flick, and of the assertions upon which they rested. Dr. Mays strongly opposed the idea that tuberculosis is contagious, in the ordinary sense of the word, and pointed out the peculiarities in the mode of development and the distribution of phthisis which are inconsistent with the theory that it is contagious. He quoted interesting reports and statistics in confirmation of this view, and laid special stress upon the utter failure of the attempt to limit the ravages of consumption in Naples by Government regulations adopted on the theory that the disease is contagious.

Dr. C. R. Earley, of Ridgway, spoke against the idea that tuberculosis is contagious and cited his experience as a practitioner for forty-three years as having furnished not a single case in which he could attribute the appearance of phthisis to contagion. He begged the members of the Society to bear in mind their own experience when they listened to the papers of gentlemen who maintained that consumption is contagious. For his own part he did not believe that this view was correct.

Dr. Traill Green, of Easton followed with the opinion he had formed from his own experience which now covered the greater part of a century, and pointed to himself as an illustration of the fact that one might have a mother die of consumption, and himself live many years in health and vigor, although for several years of his early life associating intimately with a consumptive. He did not believe that consumption is contagious and hoped that the Society would not commit itself to such a belief.

The interim between the morning and afternoon sessions was occupied by a clinic at the Pennsylvania Hospital by Dr. John Ashhurst, Jr., followed by a luncheon tendered by the managers of the hospital, and a lunch given at the Union League by the Faculty of the Medico-Chirurgical College.

AFTERNOON SESSION.

At the afternoon session, the nominating committee reported the following persons for officers for the ensuing year: President, J. B. Murdock, of Allegheny county; Vice-Presidents, L. H. Taylor, of Luzerne county; Benjamin Lee, of Philadelphia; W. W. Dale, of Cumberland county; W. S. Roland, of York county; Permanent Secretary, William B. Atkinson, of Philadelphia; Recording Secretary, Charles W. Dulles, of Philadelphia; Corresponding Secretary, J. H. Musser, of Philadelphia; Treasurer, O. H. Allis, of Philadelphia;

Committee on Publication: Ed. Jackson, chairman, Philadelphia; G. W. Guthrie, Wilkes-Barre; S. H. Gump, Bedford.

Judicial Council: Horatio C. Wood,

Philadelphia; J. S. Carpenter, Schuylkill county; L. H. Taylor, Luzerne county.

Time and place of next meeting, third Tuesday in May, 1889, in Pittsburgh.

Chairman of Committee on Arrangements, E. A. Wood.

The report was adopted.

Dr. Theophilus Parvin, of Philadelphia, then read the annual

Address on Obstetrics.

Dr. Joseph Price then made some remarks on

Pelvic Surgery by Abdominal Section,

in which he described the method exhibited by Dr. L. Senn, of Milwaukee, at the last meeting of the American Medical Association, for determining the existence and location of perforations of the bowel in case of pistol-shot wounds of the abdomen. The remarks were illustrated by an experiment of great interest and brilliancy. A dog was etherized and shot in the abdomen. Then the intestine was inflated per rectum with carburetted hydrogen gas, and a flame was applied at the opening in the abdomen. When this caused a minute explosion upon ignition of carburetted hydrogen escaping from it, the abdomen was opened by Dr. C. B. Penrose, and the perforation of the bowel was found in the upper part of the small intestine.

Dr. Mordecai Price then read a very interesting paper on

Removal of Kidney for Traumatism,

illustrated by presentation to the Society of the pistol, the bullet, the ligature, and the patient concerned. The case was one of pistol-shot wound of the abdomen in a little girl. The ball passed through the liver and wounded the right kidney. The operation consisted in opening the abdomen and removing the kidney. The recovery was excellent, so far as the nephrectomy was concerned, although there was long-continued suppuration in the wounded liver.

Dr. John B. Deaver, of Philadelphia, then read a paper on

Nephrectomy for New Growths,

which is published in full in this issue of the Reporter (see p. 772.)

Dr. S. T. Davis, of Lancaster, then read a paper on the

Removal of the Uterine Appendages; with Report of a Case,

which will be published in the next number of the Reporter.

A paper by Dr. C. B. Penrose, of Philadelphia, on

Pyosalpinx and Pelvic Abscess

was read by title and referred to the Publication Committee.

Dr. John H. Musser then read a paper entitled

Memoranda of the Life and Character of Benjamin Rush.

This paper contained an earnest eulogium of the character and attainments of Dr. Rush and a recommendation that the Pennsylvania Medical Society undertake the republication of Dr. Rush's medical works.

Dr. E. A. Wood then spoke enthusiastically upon the fame and deserts of Dr. Rush, and moved that Dr. George H. Rohé, of Baltimore, Secretary of the Rush Monument Fund, be invited to address the Society. The motion being unanimously carried,

Dr. Rohé then addressed the meeting and advocated the claims of the Rush Monument Association upon the consideration of Pennsylvania medical men.

Dr. Frederick P. Henry then read a communication from the Standing Committee of Visitors of the Asylums for the Insane in Philadelphia County, for himself and his associates on the Committee, Dr. E. T. Bruen and Dr. Alfred Whelen.

Dr. W. F. Waugh, of Philadelphia, read a paper on the

Specific Treatment of Typhoid Fever,

in which he described the benefits which he had derived from the use of sulpho-carbolate of zinc, in the treatment of summer complaint, and the way in which he came to use it for its antiseptic effect in typhoid fever. He spoke of his experience with this drug in eight cases of undoubted fever, which leads him to believe that it is one of great value in this disease.

Dr. T. D. Dunn, of West Chester, then read an interesting paper on the

Hypodermic Use of Hydrochlorate of Cocaine in Migraine and Spasmodic Asthma.

Dr. James Tyson corroborated the statement of Dr. Dunn in regard to the beneficial influence of the treatment in some of the cases mentioned.

Dr. Nancrede spoke of the occurrence of dangerous symptoms in two recent cases in Philadelphia, with death in one.

Dr. J. T. Carpenter, of Pottsville, spoke of a similar experience in which grave symptoms of collapse followed the use of cocaine.

Dr. Thomas, of Pittsburgh, spoke of the fact that the results attributed to cocaine may have been due to shock or nervous impression.

Dr. Daly uses weak solutions in treating nasal diseases, and thinks as good effects can be secured from them as from strong solutions.

Dr. Earley asked for indications for the use of cocaine.

Dr. Dunn said it was used only in severe cases, such as are described by Hughlings-Jackson under the title "nerve-storm." He knows of only four cases of death from the use of cocaine, although there seems to be such a thing as idiosyncrasy in regard to it.

Dr. C. H. Thomas referred to the experience of Drs. Thomas Evans and Arthur C. Hugenschmidt, of Paris, in the use of cocaine for the painless removal of teeth.

Dr. Tyson related the history of a case in which a solution of cocaine injected into the bladder produced symptoms which plainly indicate that it was absorbed.

Third Day, Thursday, June 7.

Dr. H. C. Wood, of Philadelphia, read the

Address in Mental Disorders,

which is published in this number of the Reporter (see p. 767). At the conclusion Dr. Wood presented the following resolution:

Resolved, That the President be directed to appoint a Committee which shall confer with the State Committee on Lunacy, and if in the concurrent opinion of the two committees any changes are advisable in our laws relating to lunacy, shall have the power to represent this body in obtaining such legislation.

Dr. J. Chris. Lange, of Pittsburgh, then read an elaborate paper on

Some Influences of Disease upon the Mind.

A paper by Dr. Hoyt, of Philadelphia, was read by title.

After the reading of this paper Dr. James McCann, of Pittsburgh, delivered the

Address in Surgery,

In which he said that the most remarkable and important advance in surgery had been in operations on the brain, and detailed several forms of operating which have been proved to be practicable and useful.

The discussion on Dr. Packard's resolution regarding the Committee on Medical Education was then taken up.

Dr. Flick strongly opposed Dr. Packard's substitute, which referred the whole matter to the Judicial Council for inquiry in regard to its conformity with the code of ethics.

Dr. J. B. Roberts also opposed Dr. Packard's substitute, and cited acts of the State Society and American Medical Association sustaining his opinion.

Dr. S. S. Cohen made the point of order, that the Society had twice passed upon the question of ethics involved by the previous approval of the resolution, and that Dr. Packard's resolution was not in order. The Chair decided the point of order well taken.

The resolution introduced by Dr. Jackson was then taken up, and after an animated discussion was finally passed.

Dr. J. V. Shoemaker, of Philadelphia, gave an outline of a paper on the

Cause and Treatment of Psoriasis,

And exhibited a patient.

During the noon recess Dr. S. W. Gross gave a clinical lecture on aseptic surgery, at the Jefferson Medical College Hospital, after which a luncheon was given the delegates in the college building.

AFTERNOON SESSION.

Dr. B. Alexander Randall, of Philadelphia, delivered the

Address in Otology,

in the course of which he asserted that the treatment of ear diseases constitutes about two per cent. of all the work of the physician. In Philadelphia there are 400 deaf mutes in the Institution for the Deaf and Dumb and about 1000 outside of the schools. If we ask the cause of deafness in these deaf mutes the answer is one that challenges attention. While the census returns set down rather more than half of the cases as congenital, more careful and thorough inquiries show that in sixty per cent. of the cases the deafness is acquired. Of some 9000 instances where the cause has been clearly ascertained, more than one-third are ascribed to scarlet-fever and measles. Among pupils in the public schools, from thirteen to twenty-five per cent. have been found with hearing less than one-third of the normal in one ear, and some seven per cent. less than one-third in both ears.

Dr. L. J. Lautenbach, of Philadelphia, read a paper on

Prevention of Ear Disease.

Colds, he said, are among the most frequent causes of ear troubles, especially those produced by leaving the head uncovered when overheated. The low-necked and sleeveless dresses of women and the evening dress of men are fruitful causes of diseases of the ear. During the fevers of childhood attention should be given to any inflammation of the throat, with a view of preventing

the danger of evil effects on the ear. The frequent washing of the interior of the ear is to be avoided, as nature provides for its cleansing by the expulsion of the wax, and swimmers should always put cotton in their ears to prevent the entrance of water. The boxing or pulling of children's ears is often attended by the most serious troubles. A most frequent cause of ear disease, especially in the young, is the absorption of nicotine from smoking tobacco, and children under 18 years should, for this reason, never be allowed to smoke.

Dr. C. H. Burnett, of Philadelphia, followed with an interesting paper on

Aural Vertigo,

and illustrated his views in regard to it by a demonstration with an imitation middle ear.

Dr. Harrison Allen, of Philadelphia, then read a carefully prepared study of

Gouty Sore Throat,

giving a description of its principal characteristics as illustrated in a number of cases which had come under his notice.

A paper by Dr. Charles H. Thomas, of Philadelphia, on

Nervous Reflexes from Eye-Strain

was then read by title.

After this the society voted to allow Dr. J. William White, of Philadelphia, to read a paper on

Operation for the Radical Cure of Strangulated Hernia,

and to exhibit two patients upon whom he had performed this operation with success.

Dr. H. F. Hansell, of Philadelphia, read a paper on

Insufficiency of the Internal Recti-Muscles.

Dr. A. G. Heyl, of Philadelphia, followed with a paper on

Two New Retinal Symptoms of Brain Disease.

Dr. Heyl called attention to the close connection between the retinal and intra-cranial circulation, and to the probability that disturbances in the latter could be recognized by the ophthalmoscope. Two abnormalities in the retinal circulation illustrating this point were then described. 1. The injection of a series of fine vessels coming off at right angles to the main retinal trunks, invisible in normal conditions. The injection causes them to become visible with the ophthalmoscope, and occurs in congested states of the meninges of the convexity of the brain. 2. An abnormal decrease in calibre of the dichomotous branches of a retinal artery. This was noticed in cases of slight mental weakness, characterized by rambling talk, loss of memory, lack of mental grasp. Cases were cited to show that the phenomenon was associated with abnormal ventricular pressure in the brain, and was probably due to an abnormal state of the large vascular trunks at the base of the brain.

Dr. Charles W. Dulles, of Philadelphia, then read a

Report on Hydrophobia,

in which he stated that the method of Pasteur had attracted much less attention during the last year than ever before, and that it seemed to be in a fair way to die a natural death. He said that the figures within his reach indicate that Pasteur practiced his method during the whole of last year only about as often as he was practicing it every month a year ago.

He showed that the effect of the method had not been to diminish the mortality from hydrophobia in Paris, for more deaths occurred in that city during the year 1887 than during 1880, 1883, 1884 or 1886. Two of the deaths occurred in persons who had been treated by Pasteur. They were explained on the ground that the method had not been thoroughly carried out in these cases.

He then submitted a brief outline of the cases occurring in the United States during the year since the Society last met, of which he had heen able to obtain any account. The cases numbered only fifteen for the whole United States—a very small number for the population, and very much smaller without Pasteur's method than had occurred in France with Pasteur's method. He desired to call attention to the principal points which had impressed him in studying the cases of the last year. Among these was the fact that the diagnosis of hydrophobia is rarely made in the first instance by the physician, but is usually only a confirmation of the diagnosis made by the laity. He also spoke strongly against the use of testing with water to determine the hydrophobic nature of the disease, and the use of forcible restraint and narcotics in its treatment.

In concluding, he expressed the hope that in time the belief in hydrophobia as a specific disease would disappear from the earth as the belief in witchcraft—which once had the support of Church and State, of the medical profession and the laity—had disappeared. He called attention to the fact that there had not been a single case of hydrophobia reported in the State of Pennsylvania during

the year just ended, and was inclined to believe that this fact had some relation to the fact that the physicians of this State are free from superstition in regard to this subject.

Dr. E. O. Shakespeare, of Philadelphia, opened the discussion, strongly opposing the opinions expressed by Dr. Dulles, and ridiculing the source of his views as "antiquarian literature." He maintained that laboratory experiments were necessary in order to determine the nature of hydrophobia. He thought that an opinion founded upon clinical observation and a study of the literature of the subject did not warrant the formation of positive opinions, but that laboratory experiments were essential to understanding it. He supported the theories of Pasteur, and claimed that rabies was analogous to other diseases communicated from the lower animals to man, and that it could no more be denied than could the communication of anthrax.

Dr. Traill Green, of Easton, supported the opinions of Dr. Dulles, and hoped he would continue to investigate the subject and report to the Society. He said he had lived a long time, and had very little faith in the current belief in regard to hydrophobia, and thought it to be the duty of physicians to allay popular fears and not to excite them.

Dr. Rahter, of Harrisburg, described the history of a case which he treated in 1870, in the person of a girl sixteen years old, which he thought could not be explained, except on the theory that hydrophobia is a communicable disease.

Dr. Charles K. Mills, of Philadelphia, referred to his investigations in regard to hydrophobia, and stated that a careful study of the details of about a dozen cases which came under his notice had led him to believe that there was not one in which the symptoms could not be more easily and rationally explained than on the basis of a belief in the specific nature of hydrophobia.

Dr. Frank Woodbury, of Philadelphia, expressed his conviction that the specific nature of hydrophobia might be regarded as one of the things that are absolutely settled in medicine. He thought the cases to be rare, but had no doubt that they occur.

Dr. Dulles closed the discussion by denying the claim of Dr. Shakespeare that clinical observation and a study of the literature of a subject do not justify the formation of a scientific opinion in regard to it, and repudiating the dictation which sometimes comes from the laboratory men to the men engaged in the practice of medicine. He pointed out, in regard to the assumption that because anthrax is communicated to a man from the lower animals, therefore rabies is so communicated; that in every disease except rabies such communication carries with it the unmistakeable signs of the disease to which it is referred; but in hydrophobia we have a disease, attributed to the inoculation of rabies, which has diametrically opposite symptoms.

After the discussion was ended, Dr. C. H. Thomas moved that Dr. Dulles be requested to continue his studies in regard to hydrophobia and to report to the Society at its next meeting, and that Dr. Shakespeare be requested to prepare and lay before the Society a paper on the evidence for and manner of propagation of rabies and hydrophobia.

This motion was adopted.

Dr. Goodwillie, of New York, then gave, by invitation, a demonstration of his method of operating in cases of cleft palate and hare-lip, which was listened to with marked attention.

Appointments by the President.

The President announced that the annual addresses at the next meeting would be delivered as follows: *In Medicine*, Dr. J. C. Wilson, Philadelphia; *Surgery*, Dr. John B. Roberts, of Philadelphia; *Obstetrics*, Dr. Francis N. Baker, Delaware; *Hygiene*, Dr. Thomas J. Mays, Philadelphia; *Mental Disorders*, Dr. Alice Bennett, Montgomery; *Laryngology*, Dr. W. H. Daly, Allegheny.

He also announced the following committees:

On State Board of Medical Examiners—Dr. L. F. Flick, Dr. Edward Jackson and Dr. W. F. Waugh, Philadelphia; Dr. E. A. Wood, Allegheny; Dr. L. H. Taylor, Luzerne.

On Pharmacy—Dr. J. W. Holland, Dr. L. Wolff, Dr. Ida V. Reel, Dr. H. Hamilton, Dr. J. G. Monnell.

On Clinical Research—Dr. John B. Roberts, Dr. J. H. Musser, Dr. Howard Allport, Dr. Thomas J. Dunn, Dr. L. H. Taylor, Dr. J. Z. Gerhard, Dr. B. C. Hirst, Dr. Rita E. Church, Dr. George Dock, Dr. Laura P. Hulme, Dr. Charles McIntyre, Dr. J. S. Carpenter, Dr. George Halberstadt, Jr., Dr. J. Madison Taylor, Secretary; Dr. F. A. Packard, Assistant Secretary.

Committee on Hospitals for the Insane.

Dr. E. A. Wood presented the following, which, he said, was satisfactory to both sides in the discussion regarding the management of hospitals for the insane on Tuesday, and which was adopted, viz.:

Whereas, the hospitals for the insane, under the care of the State of Pennsylvania,

are at present organized upon either of two radically differing plans, each claiming better results in the medical care of their inmates; be it

Resolved, That the President of this Society be directed to appoint a committee of thirteen persons, which is to include all the superintendents or chief physicians of such State hospitals, to investigate into the relative merits of the two systems, and report the results of their deliberations at the meeting of this Society in 1889.

The committee appointed is as follows: E. A. Ayres, Hiram Corson, John Curwen, H. C. Wood, S. S. Schultz, J. Z. Gerhard, R. H. Chase, Alice Bennett, G. B. Massey, Samuel Wolfe, John Fay, Traill Green, J. L. Stewart.

Committee to Revise the Constitution and By-Laws.

On the motion of Dr. O. H. Allis, a committee, consisting of Drs. William M. Welch, W. H. Parish, L. K. Baldwin, of Philadelphia; E. A. Wood, of Pittsburg, and P. T. Eisenberg, of Montgomery county, was appointed to revise the constitution of the society and report next year.

Dr. Lawrence Turnbull presented a specimen of the entire labyrinth of the ear, removed from a patient.

Reception.

A reception was given the Society in the evening by the College of Physicians, at its hall, Thirteenth and Locust streets. In the absence in Europe of the President, Dr. S. Weir Mitchell, the honors were done for the college by the Vice-President, Dr. John H. Packard, assisted by a reception committee, of which Dr. R. A. Cleemann was chairman.

Fourth Day, Friday, June 8.

At the closing session the Society considered Dr. H. C. Wood's resolution to appoint a committee of three to confer with the State Lunacy Committee, and if in their concurrent opinion any changes are needed in the State Lunacy laws, to represent the Society in urging the requisite legislation.

After brief discussion the resolution was adopted.

Dr. Packard then offered a resolution setting forth that in the sense of this body, the American Medical Association may by a vote set aside the code of ethics, and other medical societies may do likewise, and it is not in order for a member to call attention to any breach of the code of ethics.

This resolution was intended to mark Dr. Packard's opinion of the action of the Society the day before, when it was decided that he was out of order in moving to refer the matter concerning the appointment of a State Board of Medical Examiners to the Judicial Council, to decide a question of ethics. He insisted that he had been unjustly treated and the action was in contravention of law.

Dr. Jackson moved to lay the resolution on the table. The President stated that the action yesterday was apparently unanimously approved by the Society, and the motion to lay the resolution on the table was adopted.

Dr. Wood, of Pittsburgh, amused the Society by moving the adoption of a resolution that the President-elect shall take the following

"Hypocritic Oath:"

"Having been duly elected President of this Society, do you promise to hold the Pennsylvania Medical Society, as it has been held by many illustrious men, as a stepping-stone to success, as a round in the ladder of fame, as a lemon to be squeezed, as a lever to raise your hopes, as a block and tackle to exalt your ambition, as a peacock's feather in a jackdaw's tail, as a lion's skin on a sheep, a spur on knighthood's heel, a garter on the leg of a courtier, a medal on the breast of a hero, and a convenient method of advertising your business, and that as soon as your time expires you will forever after turn your back on it and ignore it. Selah!"

Dr. Wood, in closing, suggested that his resolution be referred to the "Committee on Canals and Inland Navigation."

Dr. Levis suggested that it be referred to the Committee on Lunacy.

Dr. Traill Green moved that the committee to investigate the management of State Hospitals for the Insane be authorized to confer with the Legislature. Carried.

Dr. Dulles brought up the matter of publication of transactions, and asked if the Society desired to give any instructions to the Committee on Publication.

After some discussion, a motion by Dr. Benjamin Lee was adopted, to rescind the resolution of instruction adopted at the meeting in 1887.

Dr. Hiram Corson moved that memoirs of deceased members reported by the county societies be included in the published transactions. Carried.

Dr. Jackson moved that the Recording Secretary be authorized to employ a stenographer to report the proceedings of the next session of this Society. Agreed to.

On motion of Dr. Ullom, it was resolved that the newly elected officers be installed.

Dr. Levis, the retiring President, then made a short speech, thanking the members for their kindness and courtesy to the chair, and introduced his successor, Dr. Murdock, of Pittsburgh, who briefly expressed his thanks for the high, unsought and unhoped-for honor of occupying the office filled by such great and good men as John Atlee, Samuel D. Gross, Hiram Corson, and others. He assured the members that in Pittsburgh next year they would have a hearty Western welcome.

Dr. Traill Green moved that the thanks of the Society be given to all the officers, societies and persons who have been instrumental in entertaining the members in this city.

On motion, the Society adjourned to meet at Pittsburgh, May 21, 1889.

ILLINOIS STATE MEDICAL SOCIETY.

THIRTY-EIGHTH ANNUAL MEETING, HELD AT ROCK ISLAND, ILLINOIS, MAY 15 AND 16, 1888.

Second Day, Wednesday, May 16.

Antiseptic Obstetrics.

The Chairman of the Committee on Obstetrics Dr. C. W. Earle, desired to call attention to the following questions:

First.—Does the high rate of mortality still remain in the private practice of obstetrics?

Second.—Can the extreme low rate of mortality attained in hospital obstetric practice be attained in private practice?

Not many years ago Mr. Lawson Tait paid a visit to Prof. Tarnier, at la Maternité. The professor called the attention of Mr. Tait to a linear chart on the wall of his room, showing the total death-rate of women confined in that hospital from 1792 to 1886. This record is divided into three periods: (1) that of inaction, in which the mortality was from 9.3 to 20 per cent; (2) the battle of hygiene against infection and contagion with a mortality of 2.3; (3) the victory of antiseptics, with a mortality of less than 1 per cent, and in Tarnier pavilion since June, 1880, with 785 deliveries, not a death has taken place. About the year 1847, Semmelweiss wrote: "Puerperal fever has existed for two hundred years; it is time that it should disappear."

Concerning puerperal fever in ancient times we know but little. Litzman believes it should be classed among the modern diseases. But in 1664 it raged in the Hotel Dieu, in Dublin Maternity in 1672, and again in 1774 in Paris and Dublin, and up to the end of that century in Vienna, Berlin, Giessen, Copenhagen, and at St. Petersburg. In the last named place in 1825, one in eleven died. In Lombardy between 1786 and 1887, not a patient survived. In view of these facts we are not surprised that Semmelweiss declared that it was time that this murderous mortality should disappear. In 1870 to 1872, the influences of microbes in the etiology of disease began to be noticed, and in 1878 Pasteur began his investigations, from which we commence to collect data to prove what is now known as demonstrated in regard to germs. Previous to this, however, Tarnier demonstrated the contagiousness of puerperal fever by inoculation.

About 1880, Pasteur believed he saw the microbe of puerperal fever. It has been demonstrated that (1) the air and water of the earth are crowded with organized microscopic beings; (2) they live and multiply at the expense of organized matter; (3) their penetration into the tissues produces disease; (4) the skin, respiratory and digestive passages furnish the channels into the body; (5) a healthy tissue has never produced a microbe; (6) any abrasion of tissue against which these microbes come makes it possible for them to enter the system; (7) unless germs are brought from without there can be no infection; (8) many things in regard to their virulence, nature, contagion, age, and development, are yet under consideration. The application of these principles has given the victory to antiseptics in hospitals.

As soon as it is known that confinement of a patient is about to take place, Dr. Earle is in the habit of requiring her to take a warm bath, at the conclusion of which the lower part of her person is to be washed with carbolized water. It is also requested that one or two carbolized vaginal injections shall be taken during the first stage of her labor. The nurse should subscribe to certain rules of cleanliness, and have some knowledge of the etiology of puerperal disease. The lying-in chamber should be in a room where no infectious diseases have been treated, and all bed clothing should be prepared by boiling in a given per cent. of carbolized water. Do not select a mattress which is filthy for fear that a better and cleaner one will be soiled by blood and other discharges during confinement. Do not provide pieces of old comforters, the sanitary condition of which is problematical. Do not borrow syringe or bed-pan, and assure yourself that those you have are boiled or washed in hot water and thoroughly carbolized.

Dr. George Wheeler Jones, of Danville, read a paper on

Obstetrics.

During the past year very little, if anything of special importance, has occurred in this branch of medicine which could be called strictly new. There seems to be a general tendency to a return to primitive views and older methods, although these often disguised under new nomenclature or presented under circumstances which would imply the most startling originality in both conception and technique.

Cæsarean Section.—The propriety of this operation in a large proportion of cases usually relegated to craniotomy has been presented with arguments of so forcible a character as to demand the attention of every accoucheur, and to require of each one a thorough fitness and preparation for the operation which may be required of him at any hour, although happily it may never be. The line of reasoning in favor of the operation of abdominal section is directed largely toward the rights of the child in the case, and the duty which we may owe to the one as yet unborn. With the operation, as improved and modified by Saenger, the reduction of mortality of both mother and child has been so great as to make the preference for the abdominal section not a matter of question, but greatly one of choice to every conscientious obstetrician where there is reason to presume that the child is living; and the slight resulting injuries to the mother in case of her presumable recovery would suggest its extreme propriety, if not preference, where the fœtus is dead.

Conservative Obstetrics.—The tendency of the day and hour is more and more toward conservative obstetrics—place the patient in the best possible condition and let her alone. Crede takes such extreme grounds, and goes so far in this matter that he makes his diagnosis of position, condition and advancement of cases by external palpation and manipulation of the uterus through the walls of the belly, leaving the entire genitalia alone, as a region too sacred or too dreadful to justify or permit the digital approaches of even the most skillful and aseptic of conscientious priests officiating at the alter of life, and engaged in the services devolving upon him in the second stage of human biological development. That ordinary accoucheurs will ever reach this degree of skill, or that it is best they should, is open to very serious doubt. Indeed, the amount of injury possible to both mother and child by careless external manipulation is too great to justify the efforts, except at the hands of those exceptionally skilful.

An adherence to the general rules of which Crede is the exponent, along with carefully conducted asepsis, will reduce the proportion of cases of puerperal fever to so such a minimum as to make it relatively scarcely worth considering.

It has been many a day since Dr. Jones has seen any fever in the lying-in chamber worse than a simple malaria, easily controlled by a sharp and decisive course of treatment. He believes with Crede that intrauterine douching and curetting of the uterus after labor are unjustifiable procedures, excepting in cases where there are symptoms urgently demanding it, and which are familiar to all. To resort to intra-uterine management, as a rule, cannot receive too great condemnation. There was one line of action in the management of labor to which he desired to call special attention, as he attributed much success to its careful adoption and adaptation. One is often called to see a case in which labor seems to be in full progress: strong, active pains, especially inclined to be expulsive in character. The patient has been sick perhaps several hours, and the woman's friends desire the doctor to be there to do something to terminate matters. Hot drinks and a variety of other domestic things may have been already undertaken. An examination reveals a firm, slightly dilated os, with the presenting part and uterine segment well up in the pelvic outlet, the cervix occupying almost a central position. Dr. Jones at once places his patient in the right decubitus, carefully lifts the lower uterine segment into the left ilium, depressing the fundus to the right, gives a full dose of morphine, codeia or other anodyne, and tells the woman to go to sleep, and he will return for her baby some other time. In this way he might be sent for in ten or twenty-four hours, and maybe, not for a month. When he finds the first stage completed, or the woman, without doubt, up to her full term, he repeats the procedure, expecting all irregular action to subside, leaving nature to the discharge of her special and important duties, unembarrassed by an irritable nervous system, uncrippled by a malposed womb. His object is to put off labor to the last possible moment in all such cases with the expectation of having it terminate easily and satisfactorily to all concerned.

Treatment of Extrauterine Pregnancy.—The treatment of extrauterine pregnancy has been placed upon a firm basis, from which there will not soon be any departure. Electricity has robbed it of its terrors and

placed it within the group of readily curable conditions, for which physicians can not be too thankful.

Eclampsia has another antagonist in the form of veratrum viride, which drug is being boldly advanced as a specific by several reliable practitioners. It must be given fearlessly in full doses. Its action is that of a vasomotor paralyzant.

Antipyrine and Acetanilide, especially the latter, are growing in favor as reliable remedies for controlling many of the abnormal nervous manifestations of pregnancy. They control reflex irritability in a remarkable manner, and in the cephalalgia of the first stage, where there is a convulsive action, Dr. Jones had been delighted several times with the action of acetanilide. He gives this agent in many cases in which he formerly gave an opiate, and likes its action much better.

Dr. Frank S. Johnson, of Chicago, one of the special committee to report on the present status of bacteriology in its relation to disease selected for his theme

The Bacillus in Syphilis.

Few questions he said in medicine have received more attention than that of the nature of the poison of syphilis. Early in this century the most able investigators had given it careful study, but not until within the last few years has there appeared to be any real advance in the knowledge of the subject. In 1884 and 1885 Lustgarten found a bacillus which he describes as follows: "In size and shape it very closely resembles the tubercle bacillus of Koch, and lepra bacillus of Hansen. It is sometimes bent at an angle, or is spoon-curved. In color reaction, it is also similar to the tubercle bacillus. It does not occur, however, in the tissue spaces, but is found in cells; very few are found in the lesions. They are found in all the lesions of syphilis, primary, secondary, and tertiary, and are found in the syphilitic secretions." Matterstock found also that the condition best suited to the development of the smegma bacillus were (1) a mixture of the secretion with that of sebaceous glands and macerated epithelium; (2) equable temperature of about the body warmth, and (3) an acid reaction of the cultured medium.

Dr. Johnson's conclusions are:

1. A bacillus exists, recognizable by its form, size, and color. Reaction has been found by a number of observers in all syphilitic lesions, and in all stages of the disease, and has also been found in the blood of syphilitic patients. There is a widespread belief among investigators of this subject that this organism has an etiological relation to the disease.

2. This bacillus is not uniformly found in the secretions of ulcerating, syphilitic lesions.

3. A bacillus almost identical in form, size, and color reaction has been found in the secretions of the external genitalia of healthy persons.

4. The possible presence of this smegma bacillus in the secretion of doubtful sores renders microscopical examination of the secretions in these cases nearly valueless.

Dermatology and Venereal Diseases.

Dr. H. J. Reynolds, of Chicago, referred first to a case of

Tylosis of the Hands.

In an article on the uses of concentrated lactic acid by Dr. J. P. Knoche, (*Journal Cutaneous and Venereal Diseases*, April, 1887) he states that he found that much of the thickening could be removed by rubbing in the undiluted acid for a few minutes, and by gentle scraping. He again applied it seven hours afterwards and in twenty-four hours was able to remove the thickening completely, leaving the skin soft and smooth. He then treated the parts with oxide of zinc and tar ointment, but found in about a week the growth began to reappear. The acid was again applied and repeated, using the above ointment at intervals, and after a few months of this treatment the parts remained cured. Though the affection is comparatively an insignificant one, it is not only at times extremely annoying to the person so afflicted, but likewise extremely difficult to get rid of. He also found it (when applied two or three times daily) a most efficient treatment for warts. In freckles and chloasma he found the acid when diluted to one-third its strength and applied daily to be the most efficient means employed for that purpose. After its use for a few days, with a mild ointment during intervals, these discolored patches peel off, leaving a slightly reddish surface, which disappears in a few days, leaving a good clear skin. The use of the drug is associated with much less pain than the liquor potassæ, bichloride of mercury, and other preparations used for such purposes.

Urethritis.—He had nothing to offer in advance of the old and time-honored method of treating this affection. He is in the habit himself of using a saturated solution of boracic acid for an injection, rendering the urine at the same time less irritating by the use of an alkali, and occasionally resorting to the other well-known remedies, cubebs,

copaiba, etc. Boracic acid does not produce any unpleasant symptoms, such as prostatitis, cystitis, etc., which were in his opinion brought on by strong injections.

Chancroid.—In treating this affection he had ideas which might seem in the line of advancement. During a very extensive experience in venereal diseases, he had used almost nothing in the way of medicine but pure impalpable boracic acid in treating chancroid, ordering the patient to wash the parts with soap and water, three or four times a day before applying the powder. The ulcers treated in this way would heal remarkably well. He had never found it necessary to cauterize or burn chancroidal ulcers. This drug, although not so soothing as iodoform, is in his opinion far more preferable than the latter, which is so highly extolled in such affections, and the constant use of which had compelled a patient who came under his observation to change his boarding-house nine times in three days.

Dr. G. W. Jones, of Danville, in opening the discussion, said he emphatically endorsed Dr. Reynold's treatment of gonorrhœa and chancroid. He had found nothing so useful as impalpable boracic acid in the treatment of such affections, more particularly in women where the vaginal canal could be packed with it. It was really surprising to note the rapidity with which a large number of patients got well.

Dr. J. H. Miller, of Oconee, said that in addition to boracic acid in gonorrhœa, he combined with it the sulpho-carbolate of zinc with good effect.

Dr. F. C. Robinson, of Wyanette, asked what Dr. Reynolds used as constitutional treatment for chancroidal ulcers; whether or not he relied exclusively upon the application mentioned.

Dr. W. T. Thackeray, of Chicago, said that Dr. Lee, of St. Louis, applies little tablets or granules of boracic acid within the uterus and urethral canal with an instrument which he has devised for that purpose, and which he exhibited at the meeting of the American Medical Association in Cincinnati.

Dr. Miller, of Peoria, remarked that when the practice of treating chancroids with sulphuric acid and charcoal was in vogue, he observed frequently the irritating effect and phagedenic condition which the ulcers took on, but since adopting the boracic acid treatment, which he had used almost exclusively during the past three or four years, the ulcers or sores had done much better, had healed more kindly, and no destructive action had taken place in the cases which formerly gave him so much difficulty and annoyance.

Dr. Rooney, of Quincy, asked how many days it took to cure a case of gonorrhœa with boracic acid.

Dr. Jones, of Danville, said he had seen bad cases in women get well in a week—that is, the discharge would cease in about that time.

Dr. Reynolds, in closing the discussion, said with regard to Dr. Robinson's question, he would say that nearly every practitioner recognized the fact that most local conditions, no matter how remote, were almost invariably aggravated or prolonged by disorder of the constitution, consequently appropriate constitutional treatment should be instituted. As to the time required to cure a case of gonorrhœa, statistics showed that the disease proceeds to a cure under good, careful management, hygienic and otherwise, about as quickly without treatment of the disease as with it.

Ophthalmology and Otology.

Dr. S. S. Bishop, of Chicago, read a paper on

A New Otoscope

for the diagnosis and treatment of middle ear affections under passive motion, and exhibited the instrument.

The pneumatic otoscope which he had devised for the purpose named, consists of a small milled cylinder, with an ear funnel of the most serviceable pattern at one end, and an eye-piece containing a lens, around which revolves an adjustible mirror, at the other end. In the side of the cylinder a spacious aperture admits light to the illuminating surface beneath. At the funnel end of the instrument is a pneumatic chamber provided with a rubber bulb, with a flexible tube ending in a diminutive syringe, or a lip-piece, as one may prefer. The value of passive motion in the treatment of stiff joints and atrophied tissues is well recognized in general surgery. The application of the same principle to the same conditions in aural surgery is attended with equally beneficial results.

Third Day, Thursday, May 17.

Dr. D. W. Graham, of Chicago, read a paper on

Some Points in Hernia Clinically Considered,

in which he advocated the following points: 1. An umbilical or femoral hernia with pronounced symptoms of strangulation demands herniotomy without previous resort to taxis. 2. Irreducible omental hernia, with or without

symptoms of strangulation, demands operation for the patient's safety.

The following papers were also read: on

Chronic Rheumatic Sore Throat,

by Dr. E. F. Ingals, of Chicago; on

The External Application of Sulphur in Sciatic Neuralgia,

by J. W. Cowden, of Rock Island; on the

Possibilities of Volapük or Universal Language in Relation to Medical Science,

by David Prince, M.D., of Jacksonville; on

Digestive Ferments for Dissolving False (Diphtheritic) Membrane,

by Dr. A. J. Saunier.

Officers for Ensuing Year.

President, Dr. Charles Warrington Earle, of Chicago; *First Vice-President*, Dr. P. H. Oyler, of Mt. Pulaski; *Second Vice-President*, Dr. George L. Eyster, Rock Island; *Permanent Secretary*, Dr. D. W. Graham, of Chicago; *Assistant Secretary*, Dr. T. M. Cullimore, of Jacksonville; *Treasurer*, Dr. Thomas M. McIlvaine, of Peoria.

Place of next meeting, Jacksonville, Ill.

Periscope.

The Improved Cæsarean Section, with the Report of a Successful Case.

Dr. Garrigues, of New York, contributes an article on the Improved Cæsarean Section to the *Amer. Journ. of the Med. Sciences*, May, 1888, and reports a successful case. He alludes to his two previous papers on the same subject, and still maintains that no man's name should be associated with the operation, since it "is a beautiful outgrowth of general surgical and special gynecological development, an evolution due to the combined efforts of many men working independently of each other in different countries, especially Lister, in Scotland; Spencer Wells, in England; Guéniot, in France; P. Müller, in Switzerland; Leopold, in Germany, and last, but not least, Lungren, in the United States."

In the case reported, the indication for section was general contraction of the pelvis. The true conjugate was estimated at 8 cm. (3.1 in.). Operation was decided on before labor began, and Cæsarean section selected in preference to laparo-elytrotomy or the Porro operations. The operation was begun after 12 hours of labor, and lasted 78 minutes. Sublimate solution (1–5000) was used for sponges, carbolic (1–40) for instruments. Mother and child saved. The puerperium was practically normal.

Garrigues still thinks it best to eventrate the uterus before incising it (Müller); also, to use the elastic ligature (Esmarch), which should not be tied nor clamped, but tightened and held by an assistant. He follows Frank in inserting stitches through the upper end of the abdominal incision, which are to be tied before incising the uterus, thus preventing prolapse of the uterus. Delivery by the head is preferred, since when the feet are extracted first the contracting uterus is apt to grasp the child's neck, and render delivery slow and difficult. The lower uterine segment should be avoided in making the incision, but the line of demarcation is not always plain. For suturing the uterus curved needles are preferred; for the abdominal wall, Well's long, straight, triangular needles. For suturing the uterus, interrupted sutures should be used, inserted in such a way as to bring not only the edges of the incision together, but the peritoneal surfaces also. The endometrium must be avoided. A row of superficial stitches should be inserted in a manner similar to the Lembert intestinal suture. Garrigues thinks that aseptic silk is the best suture material. Catgut is unreliable, and silver wire is more difficult to handle than silk. He does not agree with Kehrer that it is advisable to aim at coalescence between the uterus and the abdominal wall; but he follows Kehrer in inserting deep uterine sutures before removing the placenta, in order to waste no time, and yet allow some minutes for the natural separation of the placenta. No drainage is required in a clean operation. Where putrid liquor amnii or meconium enters the peritoneal cavity it should be washed out with plain water or some disinfectant fluid. Garrigues would never employ drainage primarily. Should indications arise subsequent to the operation, the abdominal wound could be re-opened and drainage or irrigation instituted. He advises against leaving a drainage-tube in the uterus, also against Leopold's practice of injecting ergotine into the uterine parenchyma, and against removal of the ovaries to prevent subsequent pregnancies—the operation is sufficiently serious without introducing unnecessary factors. In the case reported, the omentum was simply pushed above the fundus of the uterus.

Garrigues considers Cæsarean section safer for the mother than difficult extraction through the natural passages. In his experience, these difficult extractions have been in pelves with moderate general contraction, and of the male type. In this country greatly flattened pelves are rare. He is not prepared to decide as to the relative

positions of craniotomy and Cæsarean section. He alludes to the difference in mortality in hospital and private cases in America (5 out of 6 saved in hospitals, 1 out of 5 in private) under the improved operation, and considers that the cause of the bad results in private practice is the defective use of antiseptics. Delay in operating is also an important cause. Whenever possible, operation should be decided on before labor sets in, and attempts to deliver by the natural passages should not be made in cases requiring Cæsarean section. The article concludes with a review of the technique of the operation.

Treatment of Asthma.

In concluding a long article upon asthma in the *Deutsche Medizinal-Zeitung*, April 16, 1888, Dr. Brügelmann divides the disease into the following five groups, according to its causes: Nasal asthma, toxic asthma, pharyngo-laryngeal asthma, bronchial asthma, and neurasthenic asthma. He thinks that only the first and third groups belong exclusively to specialists in diseases of the nose and throat, and these only when the body is not very much reduced. The second group requires the coöperation of specialists. He approves the dictum of Boecker, that "'In the treatment of asthma, the treatment of the whole constitution of the patient is of the greatest importance." With regard to the value of certain drugs in the treatment of this disease, he says that iodide of potash is of assistance in bronchial asthma, and perhaps is of temporary service in the toxic form; while arsenic is of no benefit except in neurasthenic asthma. Cannabis indica, he says, is very uncertain. Pyridin, highly recommended by Lublinski, proved of temporary benefit in a few cases of bronchial asthma, but in all other cases, especially when severe, it failed. Amylene hydrate, recommended by Pick, did good service both in nasal and pharyngeal, and also in bronchial asthma, although very transiently. Cocaine internally, and by injections, recommended by Beschorner, is at times of surprising benefit in neurasthenic asthma, but frequently fails in the other forms, and often brings about alarming symptoms. Morphia is in all forms of asthma indispensable as a last resort. Chloral gives rest in all cases, and is likewise indispensable. As to electricity, he says that the induced current acts very strikingly in bronchial asthma, and sometimes also in toxic asthma, but in the other forms it is inactive. He has seen no results from the constant current. The smoke of some burning stramonium with sal ammoniac is one of the oldest agents, and is of great value as a palliative. It produces irritative coughing at first, but then brings quiet, especially in toxic and bronchial asthma, and to a less degree in neurasthenic asthma. In the other two forms it is inactive.

Cachexia in Graves' Disease.

In a note to the Society of Medical Sciences, M. G. Gauthier suggested the original idea that the cachexia of the advanced stage of Basedow's disease is due, at least in a large number of cases, to lesions of the thyroid gland. In time this gland becomes altered and indurated. In some autopsies in which the examination has been made with care (in about a dozen of the published case) the lesions consist of a cirrhosis, which had caused the disappearance of the glandular element; of blood cysts, infarcts, etc., and in a word, of a functional atrophy of the gland. Gauthier then refers to the fact that myxœdema is found to occur as the result of ablation of the thyroid gland in cretins, and endeavors to show that there is the closest analogy between the cachexia of myxœdema and that of Graves' disease. He thinks that lesions of the thyroid gland operate to produce what he calls thyroid cachexia, just as lesions of the lymph-producing organs produce leucæmic cachexia, and lesions of the supra-renal capsules, the cachexia of Addison's disease.

He refers to a case in which puncture of a blood cyst of the thyroid caused the symptoms of the disease to disappear, and in which a return of the cyst brought about again recurrence of the symptoms of the disease.—*Bulletin Médical*, April 15, 1888.

Strophanthus in Typhoid Fever.

While many authors advise against the employment of strophanthus in typhoid fever from fear of intestinal hemorrhage, Poulet has obtained brilliant results from its use. In the *Bulletin gén. de Thérap.*, he publishes three cases of typhoid fever in which strophanthus was of excellent service. Employed in the initial stage of the disease, one or two grains in pill form are markedly antipyretic, and what is especially noteworthy, the action was continuous or absolutely final. The temperature sank at once about two or three degrees, but never fell below normal. Contrary to the existing supposition, strophanthus protects from hemorrhage, and occasionally acts as a purgative. It exercises no especial influence upon the frequency of the pulse in typhoid.—*Wiener med. Presse*, April 22, 1888.

THE

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CHARLES W. DULLES, M. D., EDITOR.

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THE PHYSIOLOGICAL ARGUMENT IN OBSTETRICS.

Perhaps no statement is more frequently used in the discussion of obstetrical subjects than the assumed axiom that labor is a natural or physiological process. Upon this ground one practitioner bases his opposition to the use of the forceps, another to the binder, a third to antiseptic midwifery, and so on. While all will admit that labor in prehistoric woman was physiological, it is by no means true of the woman of to-day. Our maternal ancestor of prehistoric times, with perfect physical development, the result of natural life, a creature of instinct, not being guided by laws, customs or religions, living largely in the open air, or in temporary dwellings, was a very different creature from her modern representative. She did not enter on life burdened by hereditary disease. Her nervo-muscular apparatus was not disproportionately developed by force of social customs. Her mind was not developed at the expense of her body, nor her generative apparatus stunted for the benefit of her brain. Inter-marriage of different races had caused no disproportion between the size of the fœtal head and of the pelvis, nor had acquired disease caused distortion of the pelvis. So, also, labor itself was a different process, inasmuch as it was spontaneous, and not managed. Of this we can judge by our knowledge of labor among primitive people. Among these races delivery takes place in the open air or in some temporary retreat, and the mother, like the lower animals, is immediately able to care for her offspring. It has been suggested that the application of the child to the breast, or the fondling of it upon the abdomen is of assistance in causing the uterus to contract and expel the placenta and membranes. As these women do not discontinue their usual habits, gravity prevents retention of the lochia, or of the placenta within the vagina.

Dr. A. F. A. King, in a recent interesting and instructive paper (*Amer. Journ. Obstet.*, April, 1888), points out many ways in which labor is no longer a natural process, especially among the upper classes. Women are far from physically perfect. Many are cursed with hereditary disease or disease tendency. Many in childhood, some as adults, have suffered from disease resulting in distortion of the pelvic bones. The customs of the times tend to stunt the reproductive apparatus, so that the woman may go to her marriage bed with an imperfectly developed uterus, and perhaps diseased ovaries. The nervous system also is developed at the expense of the muscular system. Perhaps she is a victim of fashion in dress. "In the supple abdominal wall, where Nature has wisely placed no ribs at all, custom has added ribs of brass, and woman grapples them to her spine with hooks of steel." Likewise custom prevents pregnancy and labor from being a natural process. The continuance of sexual relations after conception finds no parallel in the rest of the animal kingdom. During labor, digital examinations are made by the doctor, perhaps by the nurse. Eve was hardly thus treated. Owing to the physical degeneracy of woman, it is considered necessary for her to remain in bed one, two or more weeks after labor. Thus drainage of the lochia is interfered with, and the dangers of putrefaction of the

discharges, not only in the bed, but within the genital passage, are encountered. Owing to diminished muscular force, and increased susceptibility to pain, labor is not so apt to be completed by the natural forces as among more primitive races. The practice of making vaginal examinations, perhaps irrigations, during labor, tends to remove the natural secretions, to impede the progress of the labor by increasing friction between the fœtal and maternal parts, and possibly, to favor laceration of the pelvic floor. The fact that woman is not dumb is a large factor in rendering labor unnatural. Perhaps she has been told of, and has practiced, the various methods of preventing conception, or of inducing abortion. From these or other causes she may enter upon her pregnancy with diseased genitals. Her manner of living during pregnancy is usually the result of advice from her friends or physician. Likewise her conduct during labor and the puerperium is directed by the dictum of the schools and not by instinct.

Hence, we may conclude that labor is seldom more than a relatively normal process; either the woman is changed from her prototype, or else her environment is radically different. Opposition to artificial assistance in labor, based upon the physiological argument, is illogical. Because her primitive progenitor was able to bring forth her young, unaided, and in safety, is no reason why modern woman should not have a difficult or delayed labor, terminated with the forceps, to the advantage of herself and offspring; the fœtal head eased through the vulva where perineal rupture is imminent; the binder applied to supply the intra-abdominal pressure which would be given by the abdominal muscles were she able to be upon her feet; noxious germs kept from her tissues by the use of antiseptic agents upon her genitals by the attendants, and even by irrigation within the birth passages—germs which are no part of a natural labor, but which gain entrance to her largely by the very means which she has taken to ensure her safety; the placenta gently expressed when she is not able to expel it so well herself; anæsthetics administered to relieve exhausting pain; and careful attention by both physician and nurse that she also may be restored to her family in usefulness and health.

SYRINGOMYELIA.

Syringomyelia is the name given to an affection of the spinal cord in which the latter becomes infiltrated with embryonal connective tissue cells which go on developing and producing connective tissue until a glioma is the result; this glioma then takes on degeneration with the formation of a cavity in the centre of the infiltrated area. The affected portion of the cord is generally the central gray matter about the commissure, but the cavity often extends backward into the posterior gray horns or into the posterior columns, and sometimes advances into the anterior cornua. In fact, the extent to which this cavity with its lateral diverticula may take the place of the normal tissue of the cord, varies from a few fine fissures to a honeycombed condition extending longitudinally through a considerable portion of the cord; the favorite seat, however, is the lower cervical and upper dorsal portion of the cord. It is not empty, but is filled with a thin and serous, or bloody, or thick and gummy fluid, or even a hyaline mass. It should be stated in passing, that this disease is to be distinguished from hydromyelus, which consists in a simple dilatation of the central canal of the cord.

Although the pathological changes in the cord which are present in this disease have been known for many years, its present name was given it in 1838 by Ollivier, and the disease has been so little studied in this country that the first and only paper written on the subject is one by Dr. M. Allen Starr, of New York, to be found in the *American Journal of the Medical Sciences*, May, 1888. Doubtless the chief reason for the lack of clinical reports on syringomyelia in this country has been the extreme difficulty in recognizing the disease. As will be readily understood from what has been said as to the patological anatomy, the clinical symptoms must be complex; in fact, so

varied are the phenomena that until recent years, as Dr. Starr shows, the possibility of a clinical diagnosis was denied. Reasoning, however, from the known function of the portion of the cord most frequently affected, the lower cervical and upper thoracic, as we have already said, it becomes evident that the first manifestations of the disease must be looked for in the upper extremity, and that as the lesion is a slowly progressive one, so the trophic and vaso-motor and sensory effects will be chronic in their character. Dr. Starr, in the article referred to, reproduces brief accounts of several very interesting cases of syringomyelia, which have been reported by German observers, from which we gather that there are certain symptoms occurring in a certain combination, which may be regarded as characteristic of this disease. In the first place, there is progressive muscular atrophy, accompanied with paralysis, affecting some or all the muscles of one limb, and usually extending to the opposite limb, and to the body, and sometimes attended with a reaction of degeneration in the paretic muscles. In the second place are vaso-motor and trophic disturbances in the affected limb, which consist of cyanosis, coldness, bullous eruptions, ulceration, abscesses, and even atrophy and fragility of the bones, and a diminution in the excretion of sweat. Finally, the sensory disturbances consist in the loss of sensations of pain and temperature in the atrophied part, although the senses of touch and location may be preserved.

While some readers may at first be inclined to think that the publication of descriptions of such rare diseases is inadvisable, to the more thoughtful it will be evident that their rarity is such in appearance rather than in reality, since a wider diffusion of the diagnostic points of the disease will lead to the detection of many cases which now go unrecognized, or are only discovered at the autopsy. That it is possible to recognize the disease clinically, Dr. Starr proves by detailing a case which he has had under observation since 1885; and since the publication of Dr. Starr's paper, Prof. Kahler's report of a case to the Verein Deutsche Aerzte in Prag has been published in the *Deutsche med. Wochenschrift*, May 24, 1888, In this case the symptoms already detailed, lead the author to the diagnosis of syringomyelia. It is also worthy of note that at the same meeting Professor Chiari, in speaking of the pathological anatomy, insisted upon the same points which have already been mentioned as distinguishing this disease from hydromyelus, although in this Drs. Frederick Taylor and Whipham are not in accord with Dr. Starr and most German authorities. Precision and definiteness in the determination of the nature and location of disease are appreciated very highly by the patient himself, even though, as in the present disease, he must be told that very little can be done for him; so that no apology is necessary for bringing this affection to the notice of our readers.

CHRISTIAN SCIENCE.

It is pleasant to note that the effects of so-called Christian Science—that mixture of fanaticism and fraud which has recently attracted to it so many silly people—are drawing down upon its devotees the condemnation of thinking men in all walks of life. Opposition to this strange delusion is no longer confined to medical men, and those who cling to it cannot now protest that those who oppose them are moved only by a desire to keep to themselves a lucrative business. All over the country the newspapers are making public the disastrous results which have followed the practice of the tenets of Christian Science, and are suggesting that those who advocate them should be treated as common swindlers. This, we believe, is a reasonable suggestion. There are doubtless many who have come to believe the teachings of the leaders of this sect, who are simply ignorant and credulous; but there are no doubt many who maintain their teachings solely in the hope of gain. The former deserve some pity; the latter deserve the penitentiary. The danger of permitting both to go unrestrained is seen in a certain number of deaths immediately traceable to the neglect of taking medical advice, and might be discovered in innumerable

instances, if we could learn of all the delayed recoveries, prolonged sufferings, and shortened lives which have been determined by this neglect.

The need for some action may be gathered from the fact that there are a number of institutions in the United States devoted to the propagation of this error. It is said that there are two Christian Science "colleges" in New York, one in Brooklyn, one in Boston, one in Milwaukee, one in Colorado, and four in Chicago, and that all are doing a flourishing business.

If this be so, it is high time that they receive the attention of the authorities. The medical societies of these cities have, we believe a duty in this matter, and might with propriety inaugurate an investigation which would place the effects of the so-called Christian Science in such a light before the public that its pernicious influences could no longer be permitted to go on unchecked and unpunished. No fear of having their motives misconstrued ought to prevent medical men from enlightening the community in regard to this delusion, and they may well add this labor to the mass of work which they are constantly doing to save their fellow-men from the consequences of their own folly.

LEGAL REGULATION OF PHARMACY.

The Sacramento *Bee* has recently called attention to the fact that there is no law which properly regulates the practice of pharmacy in the State of California. There was a law passed some years ago, which applied only to pharmacists in San Francisco; but this law proved of no effect. Since then—as well as before—the inhabitants of the whole of this important section of the country have been at the mercy of such competence in dispensing drugs as has been secured by the ordinary working of the laws of trade and the sense of responsibility which is felt by those who practice pharmacy in California.

This being the case, the people of California are to be congratulated and the druggists are to be commended, in view of the fact that accidents due to mistakes in dispensing drugs are not so common as to attract public attention, or to lead to general reprobation of so lax a system. Nevertheless, there can be no question that such a system is a shame and a disgrace to any State in which it exists. Modern society does not, and should not, usually permit a dangerous calling to be exercised with no restraints, except such as are suggested by the good or bad sense, or the commercial integrity of those who follow it; and no State ought to allow men to handle and dispense medicines—many of which are active poisons—without a legal determination of their mental and moral fitness to do so.

A number of States in the Union have laws which carefully guard the lives of their inhabitants against the dangers inseparable from an unregulated practice of pharmacy; and we trust that those which are not so civilized will soon place themselves on a level with those which are. Certainly so progressive a State as California cannot long remain in a condition of semi-barbarism in this respect; and its intelligent physicians and pharmacists should make common cause to induce its Legislature to pass, as soon as possible, a law properly regulating the practice of pharmacy, and to lessen one risk of accidental killing which now hangs over them.

VERNONINE.

A communication made May 14, 1888, by MM. Edward Heckel and F. Schlagdenhauffer to the *Académie des Sciences* calls attention to the properties of a substance for which the name "vernonine" has been proposed. It is obtained from the *vernonia nigritiana*, a plant which grows abundantly on the west coast of Africa, and which is called by the natives "batjentjor." Vernonine is the active principle of the root, and its properties are similar to those of digitalin. Its poisonous properties are much less than those of digitalin, being, according to MM. Heckel and Schlagdenhauffer, only one-eightieth as great as those of digitalin.

The experiments thus far conducted do not indicate whether or not vernonine is a valuable remedy for disorder of the heart;

but its comparative freedom from toxic properties leads to the hope that it may prove to be a useful substitute for preparations of digitalis. There have been so many substances which, within the last ten years, have been put forward as substitutes for digitalis, only to disappoint the hopes they excited, that it would not be wise to expect too much of this new one; but practicing physicians will watch with interest the developments of the physiological experiments going on in France, and be ready to welcome any evidence that it is more than a pharmaceutical curiosity.

THE MEDICAL SOCIETY OF STRASBURG.

On April 25, the *Société de Médecine de Strasbourg* was dissolved by an order of the German government, as we stated in the REPORTER, May 26. The French medical journals complain that this action was prompted by the fact that among its members were certain Alsatians who still "remembered and hoped." It is clear that this remembering and hoping seems less compatible with pure pursuit of science to the German author than it does to the French, and at this distance it would not be proper to express indignation at what may be a very proper proceeding on the part of the present rulers of Alsace. This much may be said: If the members of the Société de Médecine of Strasbourg made their body a place for cultivating feelings of enmity to their rulers it is not surprising that it has been suppressed. If they did not, this suppression is to be regretted, not only on the ground of science, but also on the ground of humanity and fair dealing. In any case we hope that our colleagues in Strasburg will find some way to continue their valuable scientific labors, and to establish a claim to the consideration and kind treatment of the government under which they live.

INOCULATION OF CARCINOMA.

The believers in the inoculability of carcinoma have suffered a disappointment. It was announced that at the meeting this year of the German Surgical Congress, DR. WEHR, of Lemberg, would give a demonstration of carcinoma nodules produced by inoculation from dog to dog. But when the Congress met, on April 6, it was found that the demonstration showed that the inoculated nodules, after a gradual increase, had diminished in size, until at the end of from six to eight weeks they had entirely disappeared.

BOOK REVIEWS.

[Any book reviewed in these columns may be obtained upon receipt of price, from the office of the REPORTER.]

PRAKTISCHE ANLEITUNG ZUR BEHANDLUNG DURCH MASSAGE UND METHODISCHE MUSKELÜBUNG. VON DR. JOSEF SCHREIBER, Mitglied der K. K. Gesellschaft der Aerzte in Wien, etc. Dritte verbesserte und vermehrte Auflage. Mit 150 Holzschnitten. Wien und Leipzig: Urban und Schwarzenberg, 1888. Practical Guide to Treatment by Massage and Methodical Exercise. By Dr. Joseph Schreiber, etc.

The earlier editions of this work, both in the original and in the English and French translations, have received so many and favorable notices that we can do no more on the appearance of this third German edition than call attention to the value it has for every physician. From no other book or books can we obtain such a complete knowledge of massage and its allied modes of treatment; and the study of the subject as described by Dr. Schreiber cannot fail to remove from the practice the air of mystery which still clings to it.

CORRESPONDENCE.

Prescription of Commercial Formulæ.

EDITOR MED. AND SURG. REPORTER:

Sir:—I beg leave to express my dissent from the views expressed in your editorial in the REPORTER, April 14. I think that the vast majority of the medical and pharmaceutical professions will agree that the prescription of commercial formulæ is an injustice to the patient *and the pharmacist*. It is not right to oblige a druggist to send to distant cities to purchase at an exorbitant price preparations which he is quite as competent to prepare from quite as good, and probably better drugs, at a much smaller profit. Nor is it right to compel a patient to pay such outrageous prices as are now asked for the most simple preparations of the most common drugs, which same preparations would be made up by any druggist for one half, and in many cases one fourth the price of the patented prescription. Such a state of affairs is not creditable to the common sense of the physician; and so long as pharmacists every day see physicians so prescribing as to

take their honest profits from their pockets, to send to manufacturing pharmacists of distant cities, it is no wonder to me that they feel obliged to take to prescribing, to eke out a livelihood. I believe that the claims of great skill, intricate and costly machinery, etc., etc., put forth by these manufacturing chemists, are all bosh, and that any ordinarily skilful druggist can compound our preparations of better and purer drugs, more accurately and more satisfactorily, at an average reduction in price to the patient, of at least 50 per cent., while themselves retaining as large a profit as before. This I personally know to be true in case of many preparations now claiming the patronage of physicians. Trusting others will more ably ventilate this imposition upon the public, I am

Yours truly, G. M. Foskett, M.D.

North Dana, Mass.,

April 17, 1888.

Notes and Comments.

Remarkable Survival of a New-Born Child.

Dr. Paul F. Mundé reports the following case to the *New York Medical Journal*, April 14, 1888: A primipara, with her child, was brought into the Maternity, Würzburg, Bavaria, in 1869, under police escort, with the following statement: While workmen were opening a sewer-drain in the yard of the residence of a well-known American merchant, whose wife was under von Scanzoni's treatment, they heard the screams of a child apparently proceeding from within the drain. On rapidly opening it, they found a full-grown new-born infant struggling in the filth, which they speedily rescued. Investigation being immediately made, in the water-closet on the *second* floor was found the cook of the family, an unmarried woman, collapsed on the floor. On being revived, she acknowledged being the mother of the child, and said that she was suddenly seized with an uncontrollable desire to go to stool, and when on the seat felt something rush from her, and fainted.

The child bore signs of having passed rapidly down the drain-pipe (in those days modern water-closets were uncommon in Germany, and most residences had merely closets directly connected with the soil-pipe, but neither trapped nor supplied with a pan). It was badly scratched and bruised, but was otherwise well, and it thrived. It weighed about ten pounds.

The mother, having concealed her pregnancy, was accused of intentional infanticide, and, despite my testimony at the trial that in the agony of the moment she was probably unconscious of the escape of the child, and was not responsible for its birth in the closet, she was sentenced to four years' imprisonment.

The distance traversed by the child was certainly not less than thirty feet, and it is marvelous that the child was not killed by the fall or suffocated in the filth of the drain. While I have repeatedly seen living and healthy children brought into the Maternity who had been dropped on the hard pavement of the street while the mothers were on their way to the Maternity, I know of no instance in my experience where a child has survived such a fall as the one I describe.

Slander, or Privilege.

It is reported from Norristown, Pa., under date of May 31, that the suit of Dr. E. M. Furey against Dr. Charles Bradley, for damages for slander, has been heard before arbitrators. Dr. Furey was an applicant for admission to the Montgomery County Medical Society about a year ago, and Dr. Bradley stated to the Society that the applicant had been guilty of criminal malpractice. He made the assertion, believing it was a duty he owed to the Society. It was testified that Dr. Furey had performed the operation alleged, and there is now a possibility that he will become the defendant in a criminal suit. The arbitrators had not yet rendered their decision when the report given above was made.

This is the case to which attention was called in an Editorial in the Reporter, July 9, 1887, and it seems likely that it will turn out as we expected at that time.

Resorcin as an Antipyretic.

Dr. W. C. Chapman in a communication to the *Medical Herald*, May, 1888, states his opinion as to the antipyretic properties of resorcin in the following propositions: 1. Resorcin, in one or two scruple doses in adults, and five to ten grain doses in children, reduces the temperature two to three degrees in about one hour. 2. The physiological effects can be watched more plainly than those of other drugs of this class. 3. When the temperature is down it can be kept there by reduced doses given one or two hours apart. 4. Being a valuable antiseptic it would seem to be especially indicated in fevers of septic origin. 5. It will be especially valuable if it is proved clearly, as circumstances now tend to show, that it deranges the organs of digestion *less* than the other antipyretics.

Medical and Pharmaceutical Congress at Barcelona.

During the time of the Universal Exposition at Barcelona a medical and pharmaceutical congress will be held under the auspices of the Council General of the Exposition, which has issued an announcement stating the regulations and giving a programme of the meeting, which is to be held from September 9–15. The programme contains a list of subjects for discussion, which cover some of the most important and most profound questions of medicine and of humanity.

We invite the attention of our readers to this meeting, and to the fact that the only conditions of membership are to send on one's name and pay ten francs. To take part in the discussions, one must have an academic degree and be engaged in the practice of a profession, or in lieu of this must submit some written work to the scientific sub-commission.

Treatment of Fetid Diarrhœa.

The following methods of treating fetid diarrhœa are recommended in the *Bulletin Médical*, May 9, 1888, and may be recommended now, when such troubles are likely to occur frequently:

℞ Salicylate of bismuth,
Calcined magnesia,
Chalk,
Phosphate of lime, of each 2½ drachms.
Rub to a smooth powder.
Sig.—A half teaspoonful twice a day.

With this give an enema composed of:

Salicylate of bismuth.....2½ drachms
Salicylic acid.....15 grains
Boiled water..... 5 fluid ounces

At the same time a strengthening diet must be used.

Another method is to use the following prescription:

℞ Naphthaline (pure),
Sugar, of each a drachm and 15 grains,
Essence of bergamot, one or two drops.
Rub to a smooth powder and divide into twenty parts.
Sig.—Take one every hour.

With this the following may be used as an enema:

℞ Naphthol, 30 grains,
Alcohol, a fluid drachm and a half. After the naphthol is dissolved, add a pint of distilled or boiled water.

NEWS.

—Mr. R. Clement Lucas has been appointed Surgeon to Guy's Hospital, London, in the place of Mr. Thomas Bryant, who has been made Consulting Surgeon.

—Dr. Mazzarini, of Bologna, who was formerly assistant to Professor Loreta, has died of splenic fever.

—A school of instruction for nurses has just been opened in connection with St. Luke's Hospital, in Utica, N. Y.

—A Mrs. Johnson, says the *Indiana Med. Journal*, June, 1888, crazed by the so-called Christian science method of healing, committed suicide after killing her little boy.

—Dr. Frank O. Stockton, formerly Professor of Laryngology in the College of Physicians and Surgeons of Chicago, has begun practice in Atlanta, Georgia.

—Dr. A. H. P. Leuf has been elected Director of Physical Education in the University of Pennsylvania, in the place of Dr. J. William White who resigned some time ago.

—An International Congress of Anthropologists has been in session in New York during the past week. The Congress met at Columbia College. A number of interesting papers were read.

—Opium smoking seems to be one of the dissipations indulged in by a few Harvard students. One of these opium smokers was recently found dead after smoking a pipe, and is supposed to have died of opium narcosis.

—Three tramps broke into the residence of Dr. William L. Yost, near Mountainville, Pennsylvania, Wednesday night, May 30, and one of them, who gave the name of George Coffin, was shot in the breast, and it is thought fatally wounded.

—It is announced that the University of Pennsylvania will soon begin the construction of a Maternity Ward on the grounds of the University Hospital. The building is to consist of a central portion and two wings. Sufficient money is already on hand to complete the erection of one wing.

—The *Berliner klin. Wochenschrift*, May 14, 1888, says that the number of approved physicians in Prussia on April 1, 1876, was 7,956; on April 1, 1887, it had risen to 9,284, an increase of 1,328, or 16.7 per cent. During the same time the population has increased only 11.2 per cent. While in the year 1876 there was one physi to 3,229 people, in 1887 there was one to 3,054. This increase is not, however, distributed equally throughout the districts of the kingdom; in fifteen districts there has actually been a diminution in the relative number of physicians to inhabitants.

HUMOR.

FARMER—"And what is your brother Frank doing now?" City Visitor—"He's paying a good deal of attention to his etching." Farmer—"Um! What is he taking for it?"

HEALING POWER.—Flossie (aged four)—"Bobby, why do they call ministers, doctors?" Bobby (a lad of considerable information)—"'Cos they make folks better."—*The Epoch.*

IT SOUNDED SERIOUS.—Husband—"I tell you, my dear, I don't have any kind of success in business. I'm afraid I have a Nemesis." Wife—"Well, why don't you see a doctor about it?"—*Tid-Bits.*

THE USUAL WAY.—"I hear that the purser is quite sick this morning." "Sorry to hear that. Followed the usual nautical course, I presume?" "What is that?" "Gone to the Doc. for repairs."—*Ocean.*

"NOW, DOCTOR," he said, as he joined the medical gentleman in the street, "in the case of a man who can't sleep at night what would you advise?"

"I would advise him to sleep in the daytime."—*Life.*

A SYMPATHETIC HEART.—Old Mrs. Bently—"I felt so sorry for a poor man te-day, Josiah. He told me he had been deef and dumb all his life, an' I give him a dime." Old Mr. Bently—"How could he be dumb an' tell ye that he was dumb?" Old Mrs. Bently—"Why, deary me, Josiah Bently, I never thought o'that."—*The Epoch.*

UNLUCKY "READING NOTICE."—"Excuse me, sir," said the business manager to the city editor, "but you promised to print that puff of Smither's dry-goods store just as I wrote it." "Well, didn't I?" "No, sir. It wasn't published at all." "Did you write on one side of the paper only?" "Certainly." "Then I guess I must have published the wrong side of the manuscript."—*Washington Critic.*

LORD ERSKINE was in the habit of making a very effective pause in all letters replying to solicitation for subscriptions. He wrote: "Sir,—I feel much honored by your application to me, and I beg to subscribe"—here the reader had to turn over the leaf—"myself your very obedient servant," etc. One of the best instances of this form of pause occurred in a letter received by a popular physician. This gentleman was pleased with a certain aerated water; and, by his recommendations, he managed to secure for it some celebrity. For this, he expected neither reward nor thanks. Imagine his surprise, therefore, when he received one day from the makers of the aerated water an effusive letter, stating that his kind recommendations had done so much good that they ventured to send a hundred —(here the page turned over). "This will never do," said the doctor. "It is very kind, but I will never think of accepting anything." Here he turned the page, and found the sentence ran—"of our circulars for distribution."—*Chamber's Journal.*

OBITUARY.

LUCIUS CASTLE BUTLER, M.D.

Dr. L. C. Butler died in Essex, Vt., May 25, 1888. He was born in Essex, Vt., March 17, 1820. He received his early education in the district and high-schools of his native town, and in Bradford Academy, Vt. He studied medicine in the office of Dr. George Howe, of Jericho, Vt., and Dr. Leonard Marsh, of Burlington. He attended lectures at Dartmouth and Woodstock Medical Colleges, from the latter of which he was graduated in 1842. From the former he received the honorary degrees of M.D. in 1875.

Dr. Butler began the practice of medicine in Clintonville, N. Y., immediately after his graduation, and resided there and in Essex and Bradford, Vt., until 1860, when he went to Philadelphia to become associate editor, with his cousin, Dr. S. W. Butler, of the MEDICAL AND SURGICAL REPORTER. In this relation he remained for two years, when he returned to Essex, where he was continuously occupied in his profession until a few weeks before his death. Dr. Butler was for eight years secretary of the Vermont Medical Society, and for three years its President. He was also a member of the American Medical Association and on its committee of hygiene. For the past six years he was a member of the Vermont State Board of Supervisors of the Insane, and for the past three years one of the U. S. Pension Examiners.

Among his published medical monographs are the following: "The Physiological Properties and Therapeutic Action of Veratrum Viride," "Cerebro Spinal Meningitis," "New Remedial Agents," "Diphtheria," "Locality of Consumption in Vermont," "Hygiene of the Farm," "Decadence of the Human Race," "Intoxication by Alcohol."

Dr. Butler leaves a widow and two children, Rev. E. P. Butler, of Lyme, N. H., Mrs. A. M. Granger, wife of Dr. F. C. Granger, of Randolph, Mass.

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Communications.

THERAPEUTICS OF DIPHTHERIA.[1]

BY A. JACOBI, M.D.,
CLINICAL PROFESSOR OF DISEASES OF CHILDREN IN THE COLLEGE OF PHYSICIANS AND SURGEONS, NEW YORK, ETC.

Mr. President:—You have conferred upon me the honor of an invitation to make some introductory remarks to your discussion on the treatment of diphtheria. This invitation I was anxious to accept, if for no other reason than to see the profession of Philadelphia at their home, and at work. That I should bring anything new to you, or striking, I never for a moment believed, since I was ever in the habit of reading your books and journals, and the proceedings of your societies. But it pleased me to infer from the demand that I should appear before you, that I was, to a certain extent, considered one of you, and to prove by my willingness to come that I appreciated the honor offered.

When I considered the subject which is to be the topic of your deliberations this evening, and remembered the vastness of its literature, it became clear to my mind that a digest, even so small, of what has been written, would fill more than many evenings, and still fall short of accomplishing the object in view. I was aware that I must not come here with literature. You will excuse me, therefore, for only detailing in plain language some of the facts gathered in my contact with diphtheria, these thirty years, and the therapeutical measures which I have learned to appreciate and to practice. Thus I shall not touch upon the large number of panaceas which have ascended like rockets and never were seen again.

[1] A paper read at the meeting of the Philadelphia County Medical Society, May 23, 1888.

Diphtheria is a contagious disease. Severe forms may beget severe or mild forms. Mild cases may beget mild or severe cases. There is probably no spontaneous origin of diphtheria, any more than there is a spontaneous origin of cholera or scarlatina. What has been called follicular amygdalitis (or "tonsillitis") is diphtheria in many, perhaps most, instances. It is seldom dangerous to the patient, because the tonsils have but very little lymph communication with the rest of the body. But the diphtheritic variety of follicular amygdalitis is also contagious. This mild variety is that from which adults are apt to suffer. It made me proclaim the warning that there is as much diphtheria out of doors as there is in doors; as much out of bed as in bed. With this variety the adult is in the street, in business, in the schoolroom, in the railroad car, in the kitchen and nursery. With this variety, parents while complaining of a slightly sore throat, kiss their children. Wherever it is suspected, it ought to be looked after. Where it is seen it ought to be isolated and treated, less perhaps for the sake of those who are sick, than of those who are in serious danger of being infected. This is the more necessary, as this form is apt to last long and give rise to repeated attacks. But it is not only the mild variety which is liable to last long. Serious, undoubted cases are also apt to last for weeks, and some of them months. As long as they do persist they are contagious.

These reminiscences and quotations from former writings must justify the preëminent place I claim for preventive treatment.

Those sick with diphtheria, severe or mild, must be isolated. If barely possible, the other children ought to be removed from the house. This can but rarely be done in the homes of the poor, in the densely populated districts. A great charity is still waiting for

its consummation, viz., that of erecting buildings, dormitories, and playrooms for those who ought to be temporarily exiled from their infected homes. A suggestion of mine, before the New York State Medical Society in its meeting of 1882, resulted in the erection of the Willard Parker Hospital of New York, for the benefit of those suffering from scarlatina and diphtheria. The erection of a sufficient number of temporary homes would be a still greater blessing to the poor, and a greater protection to the public at large. If it be impossible to send the well children away, let them remain outside the house, in the air, as long as feasible, and with open bedroom windows during the night, in the most distant part of the house; during the winter on a lower floor. Their throats must be examined every day, and their rectal temperatures taken by the mother, so that the physician may be called on the occurrence of but slight changes. The few minutes spent in this way are amply repaid by the safety they may accomplish. The attendants upon cases of diphtheria must have no intercourse with the well children; though a brief visit of the physician may not render him sick, or dangerous to others, a long exposure affects him or a nurse to a greater or less degree.

The well children of a family in which there is diphtheria, must not go to school or church. Schools must be closed when a number of pupils have been attacked; or better still, when there is an epidemic, though it may not yet have affected the school children to a great extent; the teachers ought to be taught how to examine throats, and directed to do so every morning, and send home those children who are suspected.

When an attack of diphtheria has made its appearance, it is well enough to examine the hygienic condition of the house with its deteriorating influences on the general health of the inmates, and to look after the source of the case in the persons of friends, attendants, and help. A family with children ought to insist upon the occasional inspection of the throats of their servants; those with chronic pharyngeal catarrh must not be hired. A seamstress, or laundress coming for an occasional day's work, sick nurses, children's nurses, and cooks, ought to be examined from time to time, the more so, the more such people are inclined to conceal slight troubles, for obvious reasons. The opportunities for infection are so numerous that it is impossible to sail absolutely free from it. It is easy to imagine how many cases of diphtheria are liable to be disseminated by teachers, shopkeepers, restaurant keepers, barbers, and hairdressers.

In times of an epidemic, every public place, theatre, ball-room, dining-hall, and tavern ought to be treated like a hospital. Where there is a large conflux of people there are certainly many who carry the disease. Disinfection ought to be enforced at regular intervals. In this respect I can but repeat what I said in my treatise (p. 172) and Pepper's *Cyclopædia* (I. 697). Public vehicles must be treated in the same manner after a suspicious case has been carried; that it should be so when a case of small-pox has happened to be conveyed in them, appears quite natural. Livery stable keepers who would be anxious to destroy the germ of small-pox in their coaches, must learn that diphtheria is as dangerous a passenger as variola, and what is correct in the case of a poor hack, is more so in a railroad car, whether emigrant or Pullman. I have seen many cases coming to and leaving the city in them. They ought to be thoroughly disinfected in times of an epidemic at regular intervals, for the highroads of travel have always been those of epidemic diseases. Still, can that be accomplished? Will not railroad companies resist a plan of regular disinfections, because of its expensiveness? Will there not be an outcry against this despotic violation of the rights of the citizen, the independence of the money bag? Certainly there will be, exactly as there was when municipal authority commenced to compel parents to keep their children from school when they had contagious diseases in their families, and when small-pox patients were arrested because of their endangering the passengers in a public vehicle, or taken to a fever hospital for the protection of their neighbors. In such cases it is not society, or the State, that tyrannizes over the individual, it is the individual that endangers society.

To what extent the infecting substance may cling to surroundings, is best shown by the cases of diphtheria springing up in premises which had not seen diphtheria for a long time, but had not been interfered with; and best, perhaps, by a series of observations of auto-infection. When a diphtheritic case has been in a room for some time, the room, bedding, curtains, and carpets, are infected. The child is getting better, has a new attack, may again improve, and is again stricken down. Thus I have seen them die; but also improve immediately after being removed from that room or house. If barely possible, a child with diphtheria ought to change its room and bed every few days.

To other rules of protection and disinfection, both private and public, including the prohibition of public funerals, I allude only for the purpose of referring to the admirable rules published in its *Bulletin* No. 10, of September 6, 1879, by the National Board of Health, and copied in my treatise on diphtheria, New York, 1880, and my article on diphtheria in Pepper's *System of Practical Medicine*, vol. I. p. 698.

Prevention can accomplish a great deal for the individual. Diphtheria will, as a rule, not attack a healthy integument, be this cutis or mucous membrane. The best preventive is, therefore, to keep the mucous membrane in a healthy condition. Catarrh of the mouth, pharynx and nose must be treated in time. Many a chronic nasal catarrh, with big glands round the neck, requires sometimes but two or three regular salt-water injections (1:130) into the nose, and gargling if the children be large enough to do so. The addition of one per cent. of alum will often be found useful. This treatment, however, must be continued for many months, and may require years. Still there is no hardship in it, and no excuse for its omission. The nasal spray of a solution of nitrate of silver, 1:500 or 1000, will accelerate the cure, and not infrequently has a treatment which was considered obsolete when I was young, been of great service to me. It consists in the internal administration of the tincture of pimpinella saxifraga. It is certainly an efficient remedy in subacute and chronic pharyngitis and laryngitis. I generally give it to adults, diluted with equal parts of glycerine and water, a teaspoonful of the mixture every two or three hours, with the proviso that no water must be taken soon after.

Large tonsils must be resected in times when there is no diphtheria. During an epidemic every wound in the mouth is liable to become diphtheritic within a day, and such operations ought to be postponed if feasible. The scooping of the tonsils, for whatever cause, I have given up since I became better acquainted with the use, under cocaine, of the galvano-cautery. From one to four applications to each side, or to the post-nasal space, are usually sufficient for every case of enlarged tonsils or lacunar amygdalitis. It is advisable to cauterize but one side at a time, to avoid inconvenience in swallowing afterward, and to burn from the surface inward. Cauterization of the centre of the tonsils may result in swelling, pain, and suppuration, unless the cautery is carried entirely to the surface; that is to say, the scurf must be on, or extend to the surface. Another precaution is to apply the burner cold, and heat it *in situ*.

Nasal catarrh and proliferation of the mucous and submucous tissue may require the same treatment, but in my experience the cases which require it are less frequent than cases in which the tonsils need correction. The presence of glandular swellings round the neck must not be tolerated. They and the oral and mucous membranes affect each other mutually. Most of them could be avoided if every eczema of the head and face, every stomatitis and rhinitis resulting from uncleanliness, combustion, injury, or whatever cause, was relieved at once. A careful supervision of that kind would prevent many a case of diphtheria, glandular suppuration, deformity or phthisis.

For its salutary effect on the mucous membrane of the mouth, chlorate of potassium, or sodium, which is still claimed by some to be a specific, or almost so, is counted by me amongst the preventive remedies. If it be anything more, it is, in a case of diphtheria, an adjuvant. It exhibits its best effects in the catarrhal and ulcerous condition of the oral cavity. In diphtheria it keeps the mucous membrane in a healthy condition, or restores it to health. Thus it prevents the diphtheritic process from spreading.

Diphtheria is seldom observed on healthy, or apparently healthy, tissue. The pseudo-membrane is mostly surrounded by a sore, hyperæmic, œdematous mucous membrane. Indeed, this hyperæmia precedes the appearance of the diphtheritic exudation in almost every case. The exceptions to this rule consist of those cases in which the virus may take root in the interstices between the normal tonsillar epithelia, pointed out by Stoehr but a few years ago. Indeed, many cases of throat disease occurring during the prevalence of an epidemic of diphtheria, are but those of pharyngitis which under favorable circumstances may develop into diphtheria. These throat diseases are so very frequent during the reign of an epidemic, that in my first paper on diphtheria (August 11 and 18, 1860, *Amer. Med. Times*) I based my reasoning on 200 cases of genuine diphtheria, and 185 of pharyngitis, without a visible membrane.

These cases of pharyngitis, and those of stomatitis and pharyngitis accompanied by the presence of membranes, are benefited by the local and general effect of chlorate of potassium. The surrounding parts being healthy or returning to health, the membrane remains circumscribed. The generally benign character of purely tonsillar diphtheria, which

is apt to run its full course in from four to six days, has in this manner contributed to secure to chlorate of potassium the reputation of being a ready, *the*, remedy in diphtheria. The dose of the salt must not be larger than 15 grains (1 gramme) for an infant a year old, not over 20 or 30 (1.5–2.0) for a child from three to five years old, in the twenty-four hours. An adult must not take more than 1½ drachms (6 grammes) daily. These amounts must not be given in a few large doses, but in repeated doses and at short intervals. A solution of one part in sixty will allow a teaspoonful every hour, or half a teaspoonful every half hour in the case of a baby one or two years old.

It is not too late yet to raise a warning voice against the use of larger doses. Simple truths in practical medicine do more than simply bear repetition, they require it. For though the cases of actual chlorate of potassium poisoning are no longer isolated, and ought to be generally known, fatal accidents will still occur even in the practice of physicians. When I experimented on myself, with half ounce doses, thirty years ago, the results were some gastric, and intense renal irritation. The same were experienced by Fountain, of Davenport, Iowa, whose death from an ounce of the salt has been impressively described in Alfred Stillé's *Materia Medica*, from which I have quoted it in my treatise on diphtheria. His death from chlorate of potassium induced me to prohibit large doses as early as 1860. In my contribution to Gerhardt's *Handbuch der Kinderkrankheiten*, vol. II, 1877, I could speak of a series of cases known to me personally. In a paper read before the Medical Society of the State of New York in 1879 (*Medical Record*, March 15), I treated of the subject monographically, and alluded to the dangers attending the promiscuous use of the drug, which has descended into the ranks of domestic remedies; and, finally, in my treatise (New York, 1880) I collected all my cases, and the few then recorded by others. Since that time the recorded cases have become quite numerous, and but a few days ago a few new ones were related before the Practitioners' Society of New York. The facts are undoubted, though the explanations may differ. The probability is that death occurs from methæmoglobinuria produced by the presence of the poison in the blood; though Stokvis, of Amsterdam, has tried, by a long series of experiments, to fortify my original assumption that the fatal issue is due to acute nephritis.

The attempt at forming indications for the treatment of patients with diphtheria—I refuse to say treatment *of* diphtheria—based upon preconceived or acquired ideas as to the nature and causes of diphtheria, are all futile. We know that many cases are undoubtedly of local origin; but there are those in which we require no other proof for its original infectious character than the fact that there is a period of incubation. But all that is indifferent, in view of the fact that the cases we are called upon to treat are, as a rule, or have become, both local and constitutional. It is these we have mostly to deal with.

There is no better proof of the non-existence of a specific in diphtheria than the fact that the pharmacopœia has been exhausted to find one, and new remedies, legitimate and illegitimate, are being recommended all the time as panaceas. While there are certain indications resulting from the characteristics common to all, every case must be treated on general principles, which must be applied to the prominent individual features. When there is a high temperature in the beginning, it requires all the tact of a good physician to judge of the advisability of reducing it by antifebriles, such as sponging, warm bathing, cold bathing, antipyrine, antifebrine, or the subcutaneous use of the carbamide of quinia. Convulsions may demand active treatment, such as chloroform inhalations, or chloral hydrate internally, or in the rectum. Vomiting, or other cerebral symptoms, may ask for liquids, or smaller or larger doses of opiates. A very quick and feeble pulse may require a few large doses of a heart stimulant, digitalis, strophanthus, or sparteine in the very beginning.

Renal complications are frequent, and occur at an early time. The majority of cases terminate favorably; in some a large amount of albumin will be eliminated in the course of a few days and disappear shortly. But whether or not your individual case will be of that nature, you do not know, and in time of danger nothing must be taken for granted. Milk or farinaceous diet, plenty of water, or, better, Poland, Bethesda, Seltzer, Appollinaris, or Vichy, warm bathing, warm feet, a few good doses of calomel, a number of hourly or two-hourly small doses of opium—which are better than those of digitalis—and nitroglycerine, will often prove beneficial. If a diffuse nephritis, such as is more frequently met with in scarlatina, be the result, it impairs the prognosis and requires further treatment conducted on general principles.

To what extent local treatment, if it be possible to employ it, is effective, can best

be seen on external diphtheritic surfaces, such as the cutis denuded by vesicatories, the inguinal regions sore with intertrigo, the vagina, circumcision wounds, or tracheal incisions. I have tried almost everything which has been recommended for these conditions, but am most pleased with the effect of iodol, or iodoform powdered, or one part with eight or ten of vaseline. Powders of subnitrate of bismuth, boric acid, or salicylic acid with fifteen or twenty-five times its quantity of starch, have not given me the same satisfaction.

The treatment of diphtheritic conjunctivitis requires also nothing but local measures. It consists in the application of small ice-bags, or iced cloths which must be changed every few minutes, and the frequent instillation of a saturated solution of boric acid, with or without atropia.

The local treatment of the pseudo-membranes of the fauces is a subject of great importance. To look upon them as an excretion which needs no interference, is incorrect. If it were possible to remove or destroy them, it would be a great comfort; but they can be reached only in certain places, and just in those in which they do least harm. Pseudo-membranes on the tonsils are the least dangerous, for their lymph communication with the rest of the body is very scanty. Thus almost all forms of tonsillar diphtheria are amongst the most benign, at least as long as the process does not extend. Most cases of the kind run their mild course in from five to seven days, and it is just these which have given rise to the many proposals of tearing, scratching, cauterizing, swabbing, brushing, and burning. There are cases which do not show the harm done. The fact is that neither the galvano-cautery nor carbolic acid, nor tannin and glycerine, nor perchloride or subsulphate of iron can be applied with leisure and accuracy to the very membrane alone, except in the cases of very docile and very patient children. In almost every case the surrounding epithelium is getting scratched off or changed, and thus the diphtheritic deposit will spread. Besides, the membrane of the tonsil is changed surface tissue, as it always is wherever the epithelium is pavement, and not deposited upon the mucous membranes from which it might be easily detached. Whatever is done must be accomplished without violence of any kind. If nasal injections be found advisable they can be made to wash the posterior pharynx and the tonsils sufficiently, so as to render the special treatment directed to the throat absolutely useless. Besides, it is easier, and meets with less objection, and gives rise to less exhaustion than the forcible opening of the mouth. This is of very great importance, as I shall show in connection with the local treatment of the nasal cavity. Where it is possible to make local applications without difficulty, the membrane may be brushed with tincture of iodine several times daily, or a drop of rather concentrated carbolic acid. Of powders I know only one, the application of which is not contraindicated, viz., calomel. Even this may irritate by its very form. Everything dry irritates and gives rise to cough or discomfort. Whatever has, besides, a bad taste or odor, such as sulphur, iodoform, or quinia, must be abhorred.

For the purpose of dissolving membranes papayotin, or papain, has been employed. It is soluble in twenty parts of water, and may be injected, sprayed, or brushed on. I have used it in greater concentration, in two or four parts of water and glycerine, in the nose, throat, and through the tracheotomy tube, in the trachea. One of the irrepressible drug manufacturers and advertisers pushes the claims of some modification of the drug, which he calls papoid. For the same purpose trypsin is preferred by others. The mode of its applications appears to be the reverse of indifferent. Only lately, I have seen in the practice of one of our best known practitioners, papayotin applied in powder, which resulted in constant irritation of the throat, while the patient otherwise was convalescent. The pharyngeal hyperæmia and slight exudation disappeared when mild alum washes were substituted.

Steam.—Its inhalation is useful in catarrh of the mucous membranes, and in many inflammatory and diphtheritic affections. On mucous membranes it will increase the secretion and liquify it, and thus aid in the throwing off of the pseudo-membranes. Its action is the more pronounced the greater the amount of muciparous follicles under or alongside a cylindrical or fimbriated epithelium. Thus it is that tracheo-bronchial diphtheria, so-called fibrinous bronchitis, is greatly benefited by it. Children affected with it I have kept in small bath-rooms for days, turning on the hot water, and obliging the patient constantly to breathe the hot clouds. Several such cases I have seen recover with that treatment. Atomized *cold* water will never yield the same result. Nor have I seen the patent inhalers do much good. Still, where the surface epithelium is pavement rather than cylindrical, and but few muciparous follicles are present, and the

pseudo-membrane is rather immerged in, and firmly coherent with, the surface—for instance, on the tonsils and the vocal cords—the steam treatment is less appropriate. On the contrary, moist heat is liable in such cases to favor the extension of the process by softening the hitherto healthy mucous membrane. Thus it takes all the tact of the practitioner to select the proper cases for the administration of steam, not to speak of the judgment which is required to determine to what extent the expulsion of air from the steam-moistened room or tent is permissible.

Steam can be properly mixed with medicated vapors. In the room of the patient water is kept boiling constantly over the fire-place, provided the steam is prevented from escaping directly into the chimney; or on a stove (the modern self-feeders are insufficient for that purpose and abominations for every reason); or over an alcohol lamp if we cannot do better, but not on gas if possible, because of the large amount of oxygen which it consumes. Every hour a tablespoonful of oleum terebinthinæ, and perhaps also a teaspoonful of carbolic acid, is poured on the water and evaporated. The air of the room is filled with steam and vapors, and the contact with the sore surfaces and the respiratory tract is obtained with absolute certainty.

The secretion of the mucous membranes is sometimes quite abundant under the influence of steam, but still is, like that of the external integuments, increased by the introduction of water into the circulation. Therefore, drinking of large quantities of water, or water mixed with an alcoholic stimulant, must be encouraged. Over a thoroughly moistened mucous membrane the pseudo-membrane is more easily made to float, and to macerate.

It was for this purpose that pilocarpine, or jaborandi, was highly recommended. Guttmann recommended it as a panacea in all forms of diphtheria. There is no doubt that the secretion of the mucous membrane is vastly increased by its internal application, and by repeated subcutaneous injections of the muriate or nitrate of the alkaloid, but the heart is enfeebled by its use. I have seen but few cases in which I could continue the treatment for a sufficient time. In many I had to stop it because after some days of persistent administration I feared for the safety of the patients. Thus, as early as at the meeting of the American Medical Association at Richmond, eight years ago, I pointed out the exaggerations in the statements of Guttmann. There will be but exceptional cases in which pilocarpine will be tolerated long enough to do good. It is one of the remedies with which we may cure our case and will kill our patient.

Diphtheria of the nose is apt to terminate fatally unless energetic treatment is commenced at once. This treatment consists in persevering disinfection of the mucous surface. The disinfecting procedure must not be omitted long because of the general sepsis resulting from rapid absorption from the surface, which is supplied with lymph ducts and small, superficial blood-vessels to an unusual extent. Disinfectant injections must be continued every hour, for one or more days. If they are well made, the consecutive adenitis, especially that about the angles of the lower jaw, is soon relieved and the general condition improved. But there are cases in which the lymph bodies are not the main gates through which constitutional poisoning takes place, but the blood-vessels alone. In the incipient stage of such cases the discharge from the nostrils is more or less sanguineous; in them the blood-vessels, thin and fragile, carry the poison inward with great rapidity.

In a few cases injections are unsuccessful. They are those in which the whole nasal cavity is filled with membranous deposits to such an extent as to require forcible treatment. Sometimes it is difficult to push a silver probe through it. That procedure may be repeated, the probe dipped in carbolic acid, or wrapped in absorbent cotton moistened with carbolic acid of 50 or 90 per cent. After a while injections alone will suffice. But now and then the development of pseudo-membranes is very rapid, a few hours suffice to block the nostrils again, and the difficulty is the same.

[TO BE CONTINUED.]

REMOVAL OF THE UTERINE APPENDAGES AS A REMEDIAL MEASURE.[1]

BY S. T. DAVIS, M.D.,
CONSULTING SURGEON TO ST. JOSEPH'S HOSPITAL, LANCASTER, PA.

It is not expected that the profession will be taught anything new on this important subject, but the recital of this remarkable case, with the very satisfactory results, may stimulate others to consider more seriously and thoroughly the propriety of extending to a large class of sufferers the benefits of a surgical operation as a remedial measure where medicine has hopelessly failed to give more than temporary and unsatisfactory relief.

[1] Read before the Medical Society of the State of Pennsylvania, June 6, 1888.

In September, 1887, Dr. Bushong, of New Holland, Lancaster county, Pa., consulted my brother, Dr. M. L. Davis, Medical Director of the Hospital, in relation to the admission of Miss B. W., who had been a patient of his for several years, with a view of having Battey's operation performed, if thought advisable. After her admission my attention was called to her case in consultation, when the following history was elicited:

Age, 21; date of admission, October 18, 1887; menstruated at 10½ years, with pain; father living, age, 51, always healthy; mother died at 51 from disease of the heart, following rheumatism; brothers living, 4 (28, 26, 22 and 13 years of age), all in good health; brothers dead, 3 (one 5 years old, of diphtheria, one 16 months old, of scrofula, and one infant, cause unknown); sisters living, 8 (35, 33, 20, 24, 29, 17, 14 and 11 years of age), all in good health but two; sisters dead, 1 (5 years old), of diphtheria. Paternal grandfather died at 76, of old age; paternal grandmother died at an advanced age, cause of death unknown. Maternal grandfather died at 52, of consumption; maternal grandmother died at 71 years of age, of consumption. The sister, 33 years old, has heart trouble, the result of rheumatism, and the one 24 years old suffers with dysmenorrhœa, though not in an aggravated form. The mother of the patient and four of her father's sisters were sufferers with the same disease. In the Spring of 1879 she received an injury from a direct blow in the region of the perineum, which was followed by pain, swelling and incontinence of urine; and the latter was followed in a few days by retention, the patient frequently not urinating for 24 or 30 hours. In September of the same year she fell a distance of thirty-five or forty feet, injuring the abdomen, back and side, and was confined to her bed for some time. In January, 1880, she again had a fall of twenty feet, which produced displacement of the uterus and confined her to bed for several weeks. In May of the same year she was struck a violent blow between the shoulders. In January, 1881, she contracted measles, recovery from which was slow, and was followed by an aggravation of the uterine symptoms. Shortly after partial recovery, rheumatism set in and was severe for two weeks; this was followed by paralysis of the right arm, leg, and right side of the face.

Dr. Bushong, her attending physician at the time, regarded the cause of the paralysis as reflex. Improvement began in about two weeks. She has had two similar attacks since, and recovered from them in about the same length of time. In March, 1881, at one of her menstrual periods, she had convulsions which were violent in form, and returned daily for three weeks. Since that time (about six years), they have occurred at nearly every menstrual period, and at the last one preceding the operation, I was called in consultation with the Staff Physician, who was apprehensive that death would take place at any time, as she had been in an apparently comatose condition for over twenty-four hours. The condition was not of that hysterical variety so often met with in uterine diseases and general prostration, but was of a hystero-epileptoid character, and at one time she remained in an unconscious condition for three weeks, from which she could not be aroused even by the strongest safe electric current. As before stated, menstruation appeared in 1879, when she was ten and a half years of age, and about the time that the injury to the perineum was received. During the first and second periods, the latter following the former in one month, she suffered severe pain, which continued without any remission as long as the flow lasted. After this, menstruation did not occur for six months, and then was accompanied with much more suffering than on the two former occasions, and continued for several days after the discharge ceased. From this time on the periods were irregular, sometimes recurring every month for three or six months, again being absent for a like period. The pain and general nervous debility gradually increased with each menstrual epoch, until, for the last four years, she became a helpless invalid, bedridden and dependent upon those around her for everything, and dependent upon her faithful physician even to relieve the bladder morning and evening.

From the date of the first appearance of her menses until the day she was operated upon, she was confined to her bed in all, five years, seven months and thirteen days. All means had been exhausted for her relief, short of removing the ovaries. In 1883, 1885 and 1887 she was with difficulty taken to a college hospital in Philadelphia, where forcible dilatation of the os and urethra was performed. The therapeutics of dysmenorrhœa had all been gone through with, and for the prolapsus a long list of unique-shaped pessaries had been worn. All without benefit.

Operation:—My brother, Dr. M. L. Davis, assisted by the writer, Dr. Bushong and the Hospital Staff, did the operation by abdominal incision in the median line, all antiseptic precautions being observed in detail. Both ovaries and tubes were found diseased, and bound down with the products of oft-repeated

subacute inflammations. Strong silk ligatures were applied as close to the uterus as was possible, the diseased organs removed and the pedicles dropped. The abdominal wound was closed with silk sutures, penetrating as near as possible to the peritoneum without injuring that membrane, and supported with strips of plaster. A soft, carbolated cotton pad, secured with a well-fitting bandage, completed the operation, which lasted but half an hour. The uterus was placed in, as near as possible, its normal position, and kept in blace by a soft antiseptic tampon, the object peing to get rid of the prolapsus by adhesion of the stumps to the peritoneum, at the point where the ovaries were enucleated. The patient was placed in bed on her back, sufficient anodynes were given to relieve pain, the bladder was relieved by the use of the catheter every four or five hours, and recovery was complete and rapid, without one untoward symptom. The abdominal wound healed by first intention, not even one drop of pus forming around the sutures. Since her admission to the hospital she menstruated every four weeks, the time for the fourth period coming on three weeks after the operation, at which time she suffered some pain, but was able to bear it without the use of anodynes—an unknown occurrence in the history of her long list of sufferings since she first cast an ovum, in 1879. When the second and third periods came round she had but little if any pain, simply languor. On the day of the operation she weighed about seventy-five pounds; to-day she weighs one hundred and twenty. The uterus is in almost its normal position. The catheter is no longer needed, although there is at times some slight irritability of the bladder, which will, no doubt, in the absence of the monthly congestions, yield to the power of nature to heal itself when not interfered with. I doubt very much if there is a physician within the sound of my voice who can not recall more than one case occurring in his practice in years gone by, in which this comparatively simple and safe operation would have cured more than one of his patients suffering with a complication of diseases of the pelvic organs—one in which the remedies usually prescribed tended only to aid the disease in undermining the nervous system. Some may take exception to the terms simple and safe, as applied to the operation. When using these terms I desire to be distinctly understood as referring to the operation by abdominal section, which, in my humble opinion, has more claims for simplicity and safety than either of the other methods chosen by such distinguished gynecologists as Dr. Goodell, of Philadelphia, with fifty-three operations during the past year and but a single death, and Dr. W. Gill Wylie, of New York, with one hundred and fifteen operations, and only six deaths. Considering the deplorable condition of this class of patients, as a rule, the percentage of recovery is so large that it seems to me to be malpractice to allow a well-marked case for the operation to suffer on without offering the only means of relief.

TUBERCULAR MENINGITIS.

BY G. W. GARRISON, M.D.,

UTICA, OHIO.

On Thursday, April 12, 1888, I was called to see D. S., fourteen months old, and found the little patient feverish and quite restless, with her gums swollen and her bowels torpid. I diagnosticated her condition to be a mild catarrhal fever. I gave her a mercurial laxative every two hours in a teaspoonful of syrup of wild cherry bark, with half a drop of tincture of aconite and two drops of tincture of gelsemium for the first twenty-four hours.

On the morning of the 13th, the patient was much the same. She had had several alvine evacuations during the night; her pulse was 120; her temperature, 103°; her respiration, short and frequent. She was rather disposed to be dull and stupid. I continued the former treatment with fluid diet, etc.

April 14.—The child's condition was much the same; she had less fever, but was still dull and drowsy, although not so irritable as before; her pulse was 110; her temperature, 102°. I continued the former treatment, but omitted the mercurial, as it was acting too much on the bowels. On the morning of the 15th, the symptoms remained much the same as before, and I could not understand why the disease was so hard to break up. For the next four days there was no apparent change in her condition for the better, and I became somewhat anxious about my little patient's recovery.

On the afternoon of the 20th, the mother reported the child's bowels to be again torpid, and requiring more attention than formerly. Vomiting and coughing would ensue immediately on arousing from sleep, and she had been very stupid and sleepy during the past twenty-four hours. Her eyes were partially closed when she fell into a nap, and her head was thrown back

(opisthotonus). About midnight she had a convulsion, and after that the vomiting became more frequent.

At this visit I ordered cold applications to the head, and:

℞ Potassii bromidi.....gr. j
Potassii iodidi.....gr. ¼
Misce. Sig. Give in a teaspoonful of wild cherry syrup every 3 or 4 hours.

I also ordered an enema of oil, one tablespoonful, and turpentine, 20 drops, to move the bowels.

The family history of this child may be related here. On the paternal side, some two or three children had died when quite young, and two grown brothers, aged 35 and 37 years, had died recently of tuberculosis. On the maternal side, the grandmother had died of consumption some half dozen years or so ago. So after treating my little patient for several days without any improvement, I was convinced that I was in an error in the first diagnosis, and informed the parents of my opinion, and suggested a consultation. This being agreed to, we sent for Dr. A. T. Speer, of Newark, O., on the morning of April 21. When we visited the child together in the afternoon, the child roused up and looked brighter than I had seen her look for several visits past. She played with Dr. Speer's watch and keys, but when we made a close examination she became fretful and nervous; and while we were in an adjoining room consulting, she began dozing, and threw her head back, half closing her eyes; but soon she became startled at something and roused up, coughing and crying as usual, and then began to vomit; then she fell back into a sleep again. Dr. Speer fully concurred in my opinion as to the pathological condition.

Our treatment now was: Internally, syrup ferri iodidi, five drops every four hours, alternating with gr. 1-40 of calomel and gr. j. of sugar of milk, rubbed up together; locally:

Iodoformi.....℥j
Adipis.....℥vij
M. Ft. unguent.
Sig.—Apply to entire scalp every eight hours, and cover with oiled silk and a night-cap.

Her diet was strictly liquid.

On the morning of April 22, there was a decided improvement for the better. Opisthotonus was no longer observable, the vomiting was less frequent, the cough much the same, and had she not been disturbed with a teaspoon coming at her statedly, I believe she would not have vomited any more. I discontinued the powders at this visit, and ordered one-eighth of a grain of iodide of potash to be given in a tablespoonful of water, *ad libitum*, or as often as every two hours, if she did not call for a drink. I continued the topical application of iodoform as before, for I believed that it had dissipated about all the alarming cerebral symptoms. On the 23d, the patient seemed much better, and was more rational than at any of my former visits. The same treatment was continued. This condition continued much the same at my visits on the 24th, 25th, 26th and 27th, until the morning of the 28th, when I noticed an irritable hacking cough, followed by a peculiar groan. On examining the lungs I discovered some crepitation of the left lung, posteriorly and inferiorly. I now ordered the iodoform and lard to be applied all over the thorax every eight hours, with the same precautions as when applying it to the head—where it had been discontinued for three days previously. This local treatment was kept up for three days, with calomel gr. 1-20, morph. sulph. gr. 1-100, sugar of milk gr. j, dry on the tongue every three hours. This had a very good effect in relieving all the difficulty and shortness of breathing, so that the little patient from this time (April 30 to May 2) made a rapid recovery, with all her mental faculties intact—something which it is not often a physician's good fortune to witness when having such an unfavorable family history as in this case.

I am no enthusiast over new remedies, and not prone to adopt modes of treatment other than those laid down in our text-books; but the suggestion of Dr. Speer, to use iodoform to the scalp, was well supported by the reflection that iodoform is one of our very best alteratives, and the recollection of a number of articles in the medical periodicals on the efficacy of iodoform in cerebro-spinal troubles, appearing within the last year. I attribute to its effects the restoration of our little patient to health. On May 2, after three weeks close attention, the patient was regarded as recovered, which was a great blessing to a young and happy father and mother, while I was almost as grateful as they.

TREATMENT OF WOUNDS OF THE PALMAR ARCH WITH SHOT-BAG PRESSURE; A CASE.

BY MADISON REECE, M.D.,
ABINGDON, ILLINOIS.

The editorial in the REPORTER for June 2, brings to mind three cases of wounds of the palmar arch which strikingly support the position of the editor in regard to the treat-

ment there advocated. The difficulty to be encountered, I apprehend, is in producing bearable pressure. This was the trouble which M. Bosquet feared, and failed to meet. In the following case I give the method by which I overcame this difficulty:

September 5, 1879, Mrs. H. cut the superficial palmar arch of the left hand, on the radial side, while opening a can of fruit. The bleeding was considerable, and was arrested for a time with compression applied by the husband. The next day the hemorrhage recurred to such an extent that a physician was called. The bleeding was again arrested with pressure; but as it was badly borne it was relaxed, and during the night profuse and exhausting hemorrhage took place. By this time considerable swelling and infiltration of the tissues of the hand and wrist had also taken place, and the attending physician, believing it necessary to tie the arteries at the wrist, I was sent for in consultation.

Upon arriving at the patient's home, I found the doctor had remained all night, for the reason that the amount of pressure applied caused so much pain that it had to be frequently removed, and then the bleeding would begin immediately. The patient was a spare woman, anæmic, and very nervous.

It required no great amount of pressure to control the hemorrhage, and I suggested and put into operation the following device: A small bag four inches in length and two and a quarter inches in width was made and filled with bird-shot. The forearm was placed on an elevated pillow, and the shot-bag placed lengthwise on the wrist over the arteries. The pressure was well borne, giving no pain or uneasiness. The wound began to heal rapidly, and in four days the weight was removed, and no tendency of the bleeding to again show itself was manifested.

The attending physician was agreeably surprised at the result, as he was thoroughly convinced that nothing but tying the arteries would answer. I have treated three cases of wounds of the palmar arch in this way, with the same happy results. In other cases, in which the ends of the arteries could be easily secured, I have tied both ends; but where there is secondary hemorrhage and swelling, with infiltration of the parts, as in the case above related, I believe the equable, diffused, and easily adjustable pressure made by a bag of shot, will secure the best results.

—An association of colored physicians exists in Texas under the name of the Lone Star Medical Association. Its second annual meeting was held at Austin, May 14 and 15.

Society Reports.

PHILADELPHIA COUNTY MEDICAL SOCIETY.

Stated Meeting, May 23, 1888.

The President, J. Solis-Cohen, M.D., in the chair.

Dr. Joseph O'Dwyer, of New York, read by invitation the following paper on the use of

Intubation Tubes.

[Before reading his paper Dr. O'Dwyer exhibited tubes with a metallic attachment to replace the epiglottis in swallowing, one of them being so arranged with a spring that the finger might be introduced behind it as an extractor.

In order to illustrate through how small a space breathing can occur, he exhibited a specimen from a case in which there had been no choking of voice or other sign of laryngeal involvement.

Many fear that the tube will slip through into the trachea. A tube was exhibited *in situ*, in a three-year-old larynx, showing that this accident cannot occur if the proper size of tube for the age be employed.]

The testimony of tracheotomists from the time of Bretonneau, has been uniformly in favor of canulas of large calibre. I have failed to find a single dissenting opinion on this question, yet very few have given any reason in support of their conviction, or entered into any arguments whatever on the subject, probably because they considered that none were necessary, as it appears so very reasonable that the artificial channel should approximate as nearly as possible to the normal lumen of the air-passages. I will refer to a few of the authorities on this subject before giving the reasons that led to the adoption of laryngeal tubes of so much smaller calibre than those generally used for the trachea.

If a large opening be preferable in one situation it certainly is in the other, the same argument applying to both. Bretonneau, for some reason which I have not been able to find, came to the conclusion that the canulas which he first devised were not large enough, and laid down the rule that "The artificial conduit should always have at least the normal diameter of the glottis of the subject." Trousseau endorsed this as an excellent precept, which should never be forgotten. Steiner says that as large a canula as possible should be used. The first point of importance insisted on by West, as influencing the result

of tracheotomy in croup, is the use of a large canula.

The author of the article on croup in Holmes's *System of Surgery*, says that "as a general rule, both openings in the canula should be sufficiently large to admit as much air as would pass through the rima glottidis in health."

The following is from Reynolds's *System of Medicine:* "No tube with less than a quarter of an inch diameter is sufficient to carry on respiration. At a year old such a tube cannot be introduced into the trachea; it would not be tolerated at two years old, so that at these ages some other means must be looked for to secure a passage for the air."

This author then discusses the question as to whether the want of success with tracheotomy in very young children is not due to the inability to secure a large enough opening. In answer to such assertions as the above, it is only necessary to state that the diameter of the lumen of the trachea at a year old is scarcely a quarter of an inch, and, furthermore, an adult can breathe comfortably while at rest through an opening of this size. I have at present a man under my care who has been wearing a canula in the trachea for the last seven months, the bore of the inner tube being exactly one-fourth of an inch in diameter. During part of this time he was obliged to breathe exclusively through the artificial opening, but then the least exertion, such as walking across the room, was sufficient to induce dyspnœa. Nature supplied this patient, who is of large stature, with a breathing-tube at least seven-eighths of an inch in diameter, and the surgeon substituted one having a breathing capacity of something less than one-twelfth of this. In other words, the area of a cylinder seven-eighths of an inch in diameter is a little more than twelve times that of one a quarter of an inch in diameter.

Had the surgeon who operated in this case placed himself on record, he must have taken extreme ground in favor of small canulas. Trousseau advocated larger canulas than were first used, on the ground that in some cases the improvement that at first succeeds the operation of tracheotomy soon gives place to a return of the dyspnœa, and attributes this result to the inadequate size of the canula employed, which does not provide for the permanent admission of a sufficient quantity of air. In illustration of this fact he says: "Place a quill in the mouth, and, closing the nostrils, endeaver to breathe entirely through it; at first you breathe easily enough, but soon your respiration becomes laborious, and at length you are fain to throw away the quill, and with open mouth once more to fill the lungs completely."

I have tried this experiment with a quill, the diameter of which was three-sixteenths of an inch, and could breathe through it for over five minutes without much discomfort, yet it represents in round numbers only the twenty-second part of the area or capacity of my trachea, estimating the diameter of the latter at seven-eighths of an inch. If we now construct a canula in the same ratio for a child of five years, the diameter of whose trachea is one-third of an inch, it gives a calibre of three-thirty-fourths of an inch in diameter, an opening about as large as the head of an ordinary sized pin. Trousseau's illustration, therefore, fails to sustain his argument in favor of larger tubes, as it is certain that canulas as small as this were never used. A more reasonable explanation of the return of the dyspnœa before the lapse of sufficient time for the extension of the disease, would be the entrance of blood, or the accumulation of secretions, because it occurred in only some cases, while if due to the inadequate size of the canula it should have occurred in all.

In my early experiments with intubation, the tubes had about the same calibre as those generally used for the trachea, but in order to avoid injury to the vocal cords, which I feared more than anything else, it was necessary to give them the oval or elliptical, instead of the cylindrical form. A few of these early forms I here show you. There was ample room, both in the glottis and trachea, for tubes of this size and shape. But I was not then aware of the hour-glass constriction that exists just below the vocal bands until it was demonstrated by the presence of ulceration through the whole thickness of the mucous membrane, corresponding to the long diameter, in every case in which the tube was retained for any considerable time. This defect could be remedied in only one or two ways, viz., either by diminishing the long diameter at the expense of the lumen of the tube, or by giving it the cylindrical form. The latter, by increasing the pressure on the vocal cords, would endanger their integrity, and I therefore adopted the former, and, as a result, the calibre of the tubes as at present constructed is probably less than half the original dimensions. The small calibre, consequently, was a matter of necessity, and not of choice, and if the larynx would tolerate no larger without injury, any further argument, as far as intubation is concerned, would

be useless. But from the fact that I have failed to find any ulceration at the points above indicated from the tubes as now made, I am satisfied that the cutting down process was carried further than necessary, and if demonstrated that a larger opening would give better results, this could be obtained without danger to the vocal cords by an increase of the transverse as well as the antero-posterior diameter. The bore of the smallest tube while still in the cylindrical form, which is intended for infants of one year and under, is exactly one-eighth of an inch in diameter. When we consider the size of the trachea at the same age, the disparity is not very great, and still less when compared with the subglottic division of the larynx, which is the narrowest portion of the breathing tube. This part of the larynx being completely surrounded by cartilage, is not subject to any variations in the normal condition, while the chink of the glottis may be greater or less, according to the position of the vocal cords.

I have found that in the adult the diameter of the lower division of the larynx is from one-eighth to three-sixteenths of an inch less than that of the trachea, which reduces the breathing capacity about one-third. I have not made any similar measurements in children, but by comparing a section from the cricoid cartilage placed beside one from the trachea, it does not appear that the area of the former is more than one-half that of the latter; in other words, the disparity is greater in children than in adults. In the preceding calculations I estimated on the size of the trachea, simply because it was more convenient, but it is evident that in order to arrive at correct conclusions, we must compare the lumen of the canula with that of the infraglottic division of the larynx, because the trachea would conduct air to and from the lungs just as well were it no larger than its mouth. But, as I have already stated, it was not from any such comparisons with the normal calibre of the larynx that the tubes have reached their present dimensions, but from noting the results of pressure on the intensely inflamed and infiltrated tissues as found post-mortem.

After an experience with tubes of various sizes in over two hundred cases of croup, besides other forms of stenosis of the larynx in children, I am fully convinced that, as at present constructed, they afford ample room for carrying on the respiratory function in the most perfect manner. When the disease is confined to the larynx and upper portion of the trachea, it is not an uncommon experience, after the paroxysm of coughing that immediately succeeds intubation has subsided, to find the little patient breathing so quietly and imperceptibly that it is sometimes difficult to convince the mother, who has returned to the room after an absence of fifteen or twenty minutes, that her child is still living. Such complete freedom of respiration would be impossible were the opening too small. When the struggle for breath has continued long enough to produce extreme exhaustion, together with more or less atelectasis and congestion of the lungs, this perfect relief does not occur. The same is true after the partial asphyxia induced by prolonged or repeated attempts to insert the tube. Such cases sometimes never rally, although air enters the lungs in the freest possible manner.

If any dyspnœa whatever remain for any considerable time after intubation, or if the respiration be much above the normal in frequency, it indicates the presence of some complication or extension of the disease below the tube. The fact that on several times removing a tube from the larynx I have found its calibre considerably reduced by firmly adherent secretions, when there had been no dyspnœa to indicate it, is good evidence that there is more room than is actually required for the free entrance and exit of air. Physiology teaches us that the muscular system is the great consumer of oxygen, and that when this system is at rest the consumption of oxygen is reduced to a minimum. It has been estimated that as much oxygen is consumed during one hour of active exercise as would suffice for four hours in a state of repose, with food, and for six hours without food. On purely physiological grounds, therefore, if only one-fourth or one-sixth of the amount of air is required in a state of rest, a canula bearing this proportion to the normal lumen of the air passages should afford ample room for the perfect performance of the respiratory function without the least effort whatever.

There would be no point in trying to determine through just how small a fraction of the normal lumen of the air-passages it is possible to carry on respiration effectually, if the only object to be accomplished by the artificial channel were to allow the free passage of air to and from the lungs. There would then be no room for argument, as there could be no objection to having the canula many times larger than necessary for this purpose, for such exists in the normal condition. I will add further, that were there no abnormal secretions to be gotten rid of, there would still be no reason for difference of opinion on this question. The only ground left for argument, therefore, is the manner in which the

machinery concerned in the removal of secretions is modified or injured by a canula in the larynx or trachea. The mechanism of coughing, as I understand it, is simply getting as much air into the lungs as possible, condensing it, and allowing it to escape suddenly, on the same principle as the air-gun. To accomplish this, the glottis is firmly closed, coincidently with spasmodic contraction of the expiratory muscles, until the imprisoned air is sufficiently compressed, not only to give it power to project any offending substance before it like the ball from an air-gun, but also to increase the friction between it and the lining membrane of the air-passages to such a degree as to scrape off, so to speak, secretions that may be adherent.

Considerable condensation, with great velocity of the expired air are, therefore, necessary to give the maximum expulsive power. The latter without the former would accomplish nothing, because the same volume of air can be driven through the open or half-open glottis just as rapidly as in the act of coughing, without the least power to remove a particle of mucus even from the larynx, much less from the bronchial tubes. This can be demonstrated by trying to cough while retaining the vocal cords in the expiratory position—the lack of power resulting solely from inability to compress the air to any appreciable extent. Coughing through a canula is identical with this act when performed with a partially open glottis, and the only means left of subjecting the air to any condensation whatever is the much shorter time occupied in expelling it through the same space by which it more slowly entered.

An excellent and forcible illustration of this argument, and one the mechanism of which is identical with that of coughing, is the familiar act of blowing the nose. There is little if any ability to remove secretions from this organ without first reducing the nostrils to a small fraction of their normal calibre, or by momentarily producing complete occlusion, as in closing the glottis, until the air is sufficiently condensed to force the secretions out with it. Very little power can be developed even by closing one nostril and forcing all the air through the other, if normally patulous. If secretions can be removed more effectually from the air-passages through a canula of the dimensions advocated by the authorities already quoted, for the same reason it should be easier to remove accumulations from the nose without compressing the nostrils. I claim, therefore, that while the artificial opening must be large enough for the perfect performance of the respiratory function, the power to expectorate is still further diminished, and in exact proportion to its increase beyond this limit.

MEDICAL SOCIETY OF THE COUNTY OF NEW YORK.

Stated Meeting, May 28, 1888.

The President, LAURENCE JOHNSON, M.D., in the chair.

The Sanitary Condition of the Croton River Water-Shed.

DR. JOHN C. PETERS made the report, which was verbal, and was for the purpose of inducing action on the part of the State Senate Investigating Committee to put an end to the nuisances existing on the Croton watershed, which were polluting the drinking water of the citizens of New York. Dr. Peters said the committee appointed by the County Society last year had been unable to get the city officials to take action in abating the nuisances, and there was now much greater necessity for it since the railways and land speculators were offering inducements to people to settle in the vicinity of the lakes from which the city got its water. About three years ago the population of the Croton watershed was twenty thousand; there were about nineteen hundred privies, six hundred barn yards, five cemeteries, several milk factories, over a thousand cattle and horses, etc., the sewage from which entered the Croton water. The comparative purity of the waters of Berlin, London, Boston and New York was estimated from the fact that the water of Berlin contained 99 bacteria to the cubic centimeter; that of London 44, and that of Boston 43, while that of New York contained 526. It was possible, through the sewage contamination taking place at the source of the Croton waters, for infection to occur at any day with the germs of typhoid fever, scarlet fever, etc. Indeed, the speaker suggested that it was not impossible that some of the numerous cases of scarlet fever and diphtheria which had for some time constantly prevailed in the city, had their origin in the Croton waters.

Acute Articular Rheumatism in the Nursing Infant.

DR. HENRY KOPLIK read a paper showing that the existence of acute articular rheumatism as an independent affection in the nursing infant is scarcely recognized by many writers. He gave the histories of two cases which had come under his own observation, one being that of an infant six months old, which had had pain, redness, and swelling in the feet and hands for five days before he saw

it. When he was called the temperature was 105.5° F., and the other symptoms were still present. On the eleventh day the rash of scarlet fever made its appearance. The tenderness of the affected joints subsided completely after eight weeks, and the recovery was complete. He thought the rheumatism and scarlet fever were, considering that the one preceded the other for so many days, quite independent of each other. The second case was that of a child nine months old, the feet and hands being affected, the temperature rising only to 102.5°. In neither case was there synovitis or cardiac complication. In the diagnosis Dr. Koplik excluded rheumatoid affections and obscure affections of the bones and joints, such as sometimes occurred in syphilis, rachitis, peri-articular abscess, osteomyelitis, etc.

The society then adjourned until the fourth Monday in September.

Hospital Notes.

THE HYGIENE OF THE BREASTS; TREATMENT OF PUERPERAL NIPPLE LESIONS, AND MAMMARY ENGORGEMENT, AT THE PHILADELPHIA LYING-IN CHARITY.

BY CHARLES P. NOBLE, M.D.,
SENIOR ASSISTANT PHYSICIAN.

Hygiene of the Breasts.

In view of the importance of the function which the breasts perform after child-birth, great care should be taken to have them in good condition for their work. A special indication for prophylactic care is the fact that an unhealthy state of the skin covering the nipples is a predisposing cause of nipple lesions during the puerperium. Many patients at this institution are unmarried primiparæ, and among this class diseases of the breast are most common. From motives of shame, many of them lace until their admission, compressing their breasts and nipples as well as their waists. Among hospital patients, habits of cleanliness are not very common, or their ablutions are limited to the face, neck, and hands. Hence, especial care on the part of the physician is necessary for these cases. In addition to the general baths which all waiting women receive, they are directed to wash the breasts with soap and water once or twice daily—on rising and retiring—taking care to remove collected secretions; also to apply a dilute spirit lotion, as cologne water, bay rum, or whiskey. There can be no question that cleanliness promotes the normal activity of the skin, or that alcoholic lotions, by slightly hardening the epidermis, tend to prevent maceration and erosions of the nipples in the beginning of lactation. The hardening process should not be carried too far, lest it destroy the suppleness of the skin, and thus defeat its object. When the nipples are more or less depressed, directions are given that they be gently elongated by traction with the thumb and fore-finger for a few minutes, twice daily. In these, and all other cases, the clothing is so arranged as neither to confine the breasts nor the abdomen. Where depression is marked, it not uncommonly happens that elongation is not secured by these measures. Nothing is then left but the use of the nipple shield during lactation, or it may be necessary in some cases to wean the infant. No reflex effects upon the womb have been observed.

Treatment of Puerperal Nipple Lesions.

Aside from ante-partum prophylaxis, much can be done in preventing these painful and really serious conditions. Sore nipples are usually caused by a constant moist condition, leading to maceration, exfoliation, and excoriation; or, by traumatism inflicted by the infant in suckling. When the infant is vigorous and the milk supply scanty, ecchymoses are apt to form on the crown of the nipple from the powerful suction, and when, as commonly happens, the epithelium subsequently exfoliates, an erosion or a fissure results. Hence, the nipples are carefully dried after each nursing, being first washed with a saturated boric acid solution, or a weak solution of borax. Also, until lactation is well established, it is not considered advisable to put the infant to the breast more frequently than once in four hours. Success in the treatment of sore nipples largely depends on beginning treatment early. For erosions, the compound tincture of benzoin is applied to the dried nipple with a camel's hair pencil—one or perhaps two coats after each nursing. Unless improvement follows in a few hours, Needham's nipple shield is used. (A practical point in the use of the shield is this: the nipple furnished is made of light rubber, and is somewhat stiff. If one of black rubber, such as are kept in the shops for nursing-bottles, be substituted, the child will have less difficulty in nursing, as the black rubber is softer and more pliable.) Nursing from the affected breast is allowed only at longer intervals. If true ulceration

is present, a solution of silver nitrate (ten grains to the fluid ounce) is applied, and nursing temporarily suspended. Cases of extensive ulceration have not been met with. For fissures, the solution of nitrate of silver is used, or the pointed, solid stick. The fissure may then be covered with collodion, or iodoform-collodion. But rest is what is required, and unless the remedies yield prompt results, nursing must be allowed only at longer intervals, or suspended for twelve or twenty-four hours. The shield does not give as much comfort in fissures of the base as in lesions of the summit of the nipple. A layer of cotton over the breast and a well-applied bandage is used to control milk secretion while rest is secured. All applications are washed from the nipple before the child is allowed to nurse. Cases of inflammation of the entire nipple structure have not occurred. All the cases at the Charity have yielded kindly to these measures. Mastitis has rarely followed, and in but one case has abscess resulted. The danger of infection by microbes should ever be borne in mind, and were greater care taken of nipple lesions mastitis would be a less common complication of the puerperal state.

Treatment of Mammary Engorgement.

While the occurrence of milk fever is no longer admitted, it is true that in certain puerperæ, symptoms are present about the third day which are caused by the establishment of lacteal secretion. In these cases the thermometer registers under 100° F., and usually does not exceed 99.4°. The pulse is but slightly if at all quickened. The patient is restless and perhaps thirsty. The breasts are swollen and somewhat painful, the pain perhaps extending into the axillæ. The condition is one of mammary engorgement, with constitutional irritation. The indications are to lessen milk secretion and hyperæmia of the breasts, and allay the constitutional symptoms. For this purpose the patient is put upon dry diet; is given a saline purge; full doses of sodium bromide, as much for its sedative effect as for its supposed action on secretion of milk; perhaps, also, the iodide of potassium. Locally, castor oil is used. It is smeared over the breasts (not rubbed or kneaded in, for such rubbing, stroking or kneading only increases hyperæmia and milk secretion, (*ubi irritatio, ibi fluxio*), and they are then covered with a piece of soft flannel or cotton wool. A bandage best relieves the sensation of dragging, and puts the breasts at rest. The "roller" is not necessary; besides it interferes with nursing and requires the woman to remove her clothing and sit up during its application. A modification of the bandage used in the Boston Lying-in-Hospital, described in Worcester's book on Nursing, has been employed. It is applied as follows: A bandage about six feet long and three inches wide is doubled, and reversed on itself in the centre—this forms a V. To the apex of the V, a strip of bandage is pinned, forming a Y. The leg of the Y is passed under the back, the apex of the original V being applied to the outer side of the left breast. The arms of the Y are then carried across the chest, one above, the other below the breasts, and brought together upon the outer side of the right breast. They are fastened together and to the leg of the Y (the strip which was passed under the back), by a single pin. These two pins control the bandage. These can easily be arranged so that the breasts are lifted toward the median line, and slightly compressed. The process is completed by passing a strip around the neck and fastening the ends to the bandage, first named, over the sternum; or a strip may be passed over each shoulder and fastened to the encircling bandage at the back and front. This elevates both breasts toward the shoulders. Added comfort is gained by laying cotton wool or a folded napkin over the breasts before the bandage is applied. After a little experience, it is easily and quickly done without disturbing the patient. By the removal of a pin, one breast may be exposed for nursing. Under this method of treatment, doubtless aided by the course of nature, the symptoms usually subside within twenty-four hours, and the patient in the meantime is made much more comfortable. In no case has mastitis resulted.

—At a meeting of the Academy of Sciences in Paris, April 30, 1888, M. Bimar announced the results of some investigations which he had made in regard to the distribution of the spermatic artery in man. The spermatic artery in man is distributed to the testicle only after division in the substance of the albuginea, and at the internal surface of this membrane. Its ramifications penetrate the substance of the testicle at different points on its surface and describe loops in its interior with their convexity directed toward the corpus Highmorianum, and from this smaller branches are distributed to the lobules. This mode of distribution is analogous to that seen in all mammals, especially in the ruminants.—*Gazette Hebdomadaire*, May 11, 1888.

Periscope.

Cancer of the Stomach Rupturing Externally.

Among some clinical observations published in the *Charité Annalen*, 1887, O. Fraentzel reports a case of cancer of the stomach, which ruptured externally. From this account it appears that in the pit of the stomach there was a distinct round tumor, which was soft to the touch and painful upon pressure. Somewhat to the right of the xyphoid process was a prominent spot which was tightly stretched and showed fluctuation. A needle was thrust into the fluctuating part of the tumor, and one and three-fourth ounces of a thick, cloudy fœtid fluid, mixed with air bubbles, were evacuated; the fluid was not of a distinctly foul odor, and it contained pus, fat and detritus. Subsequently under an anesthetic, the little fistula was divided, and entrance gained to a cavity the size of a small apple, which was filled with ichorous, foul smelling pus. Coughing expelled air which stank like carrion. At the autopsy a tumor the size of a hen's egg was found in the region of the pylorus. The interior of this tumor had broken down in suppuration, and in some places where the decay reached to the periphery of the tumor there was a direct communication with the abscess.—*Deutsche Medizinal-Zeitung*, April 16, 1888.

Penetrating Wounds of the Abdomen.

At the meeting of the Surgical Society of Paris, April 25, 1888, M. Le Fort made some remarks upon penetrating wounds of the abdomen. He thought it important to distinguish in such cases the point at which perforation occurred, for the prognosis varies very much according to the organs wounded. In illustration of the statement that wounds of the stomach are infinitely less grave than those of some other organs, he mentioned a case in which two butcher boys had been amusing themselves, after dinner, fencing with knives. One of the boys had his stomach perforated in such a way that the abdominal wound gave vent to some vegetables and meat which the injured boy had swallowed some moments before. The next day, and even during the four hours following, particles of food were discharged from the wound. Nevertheless recovery was perfect. M. Le Fort then went on to say that one of his students in a thesis upon this subject has collected eighty-eight cases of wounds of the stomach, of which number there were seventy-five recoveries. In fifty-two cases there was no surgical operation. In the twenty-three remaining cases, the interference was insignificant, except in a case of Larrey's in which the wounds in the stomach and abdomen were so large that a true laparotomy was done, followed by sutures. Le Fort thinks it is a mistake to say that the absence of peritonitis as a sequel to an abdominal wound is an indication that there actually is no perforation. Examples to the contrary, he says, are numerous and manifest.

From a series of ninety-five experiments made upon the cadaver, he concludes that wounds below the umbilicus are always perforating, and the frequency of perforation diminishes with the height of the seat of injury.

He agrees with M. Reclus that a distinction should be made between wounds made with pistol-balls, and those made with large projectiles. In the former case a plug of mucous membrane may possibly frequent extravasation. In wounds with balls of small calibre, refraining from operation should be the rule. Laparotomy should be done only when accidents arise, for it is an operation which is long, difficult and dangerous.—*Bulletin Médical*, April 29, 1888.

Acute Iodine Poisoning.

In the *Therapeutic Gazette*, April, 1888, Dr. W. O. Culpepper, of Barbadoes, reports the case of a colored boy 11 years old, upon whose leg two drachms of some preparation of iodine had been applied on Tuesday, January 17, about 9 P.M., for a skin affection. The application removed all the skin from above the knee to below the ankles upon both legs, leaving a raw surface as though it had been scalded. The same night, and on Wednesday, the child's suffering seemed to be local; but on Wednesday night he was seized with headache, pain in the back over the kidney, pain over stomach and bowels and bladder, and did not appear to have passed water. These symptoms became worse on Thursday, and there was also some diarrhœa and vomiting along with great thirst. The boy says he passed water once, the mother said that he tried several times but did not pass any.

On Thursday night the pains seemed to have reached their greatest intensity, and hiccough came on. The slightest movement induced vomiting and hiccough, and there was constant thirst and ineffectual attempts at urination. Constant spitting was stated to have been present at this time. On

Saturday morning Dr. Culpepper was sent for. He found the child vomiting, purging, hiccoughing, crying continually for water and bringing it up as soon as swallowed. No loss of consciousness, and no pain complained of except in the head and over the bladder. Temperature 98.8°, pulse rapid, but its force good. The skin was dry, and so were the tongue and buccal mucous membrane. The pupils seemed to be normal. The child complained of being giddy when his head was lifted, and he was said to have fainted away several times. The abdomen was flat, and there was no urine in the bladder; priapism existed. During Saturday he somewhat improved. Iodine was found in the feces. On the next day he grew worse; stools contained mucus and blood. His symptoms steadily became worse, the pains in the abdomen returned, but the intellect remained clear. He died at 4 A.M., Monday morning. His mother raised him to let him move his bowels, and soon after he passed away quietly and without pain; before death his stools were said to have become almost pure blood. His lungs were apparently unaffected.

State of the Gastric Juice in Febrile Diseases.

L. Gluzinski, in a communication to the *Deutsches Archiv für klin. Medicin*, Bd. XLI, endeavors to determine what change the function of the stomach undergoes during fever, and what the cause of the dyspepsia is. He examined fifteen patients with a view of deciding this question. The method of experimentation was to aspirate and test the contents of the stomach, after the administration of the white of one egg. The results obtained in typhus fever, pneumonia and typhoid fever, are as follows: 1. During the entire continuance of the fever, with the exception of the concluding stage of typhoid fever, the gastric juice contains no hydrochloric acid. 2. The juice has no digestive power, either in the organism or outside of it—contains no peptone. 3. After the addition of hydrochloric acid good artificial digestion is brought about, which shows that there was enough pepsin in it. 4. With the subsidence of the fever a gastric secretion having digestive power is furnished.

In chronic febrile diseases, such as phthisis and pleurisy, there was, however, a normal gastric juice during the fever. It seems, therefore, that under similar conditions the state of the gastric juice in febrile diseases is not so much influenced by the increased temperature as by the kind of infection.—*Deutsche med. Wochenschrift*, May 17, 1888.

Influence of the Bitters upon the Function of the Stomach.

N. Reichmann publishes a communication in the *Zeitschrift für klin. Medicin*, Bd. XIV, entitled an experimental investigation concerning the influence of the bitters on the function of the stomach in health and disease. His investigations were limited to the human stomach. In his tests he employed centaury, trifolium, gentian, quassia, and wormwood. Cold infusions (12 parts to 200) of these bitters were given without food, and before or during a test-meal of distilled water and albumen. The result showed that after the administration of these bitters, which all act alike, the secreting power of the stomach is less than after the taking of distilled water. But when the drug is eliminated from the stomach, the secretory apparatus is excited to increased activity. If food and the infusion were swallowed at the same time, both the secretory and the motor function of the stomach were impaired.

Of course the practical lesson to be learned from this is, that bitters should be used only in cases in which the gastric juice is diminished, and that they must be taken about half an hour before food.—*Deutsche med. Wochenschrift*, May 17, 1888.

Microörganisms of the Male Urethra and of Normal Urine.

Lustgarten and Mannaberg (*Vierteljahresschrift für Dermat. und Syph.*, vol. XIV, p. 905) removed, by means of a previously heated platinum spoon, portions of the secretion of the mucous membrane of the normal urethra. Among the great variety of bacterial forms found, there were two of special diagnostic interest. One was a bacillus morphologically identical with the bacillus tuberculosis, and the other a diplococcus in no wise distinguishable from the gonococcus of gonorrhœa. The bearing of this discovery upon the examination of urine for tubercle bacilli in cases of suspected tuberculosis of the genito-urinary organs is obvious. For such examinations they recommended catheterization with a sterilized catheter, since it was found by culture experiments that urine so obtained, not having passed through the urethra, was in most cases free from microörganisms.—*American Journal of the Medical Sciences*, April, 1888.

Fluctuation in the Amount of Hydrochloric Acid in the Stomach.

P. W. Burschinsky (*Wratsch.*, No. 47, 1887) experimented upon fourteen thoroughly healthy men in the following manner: About

nine o'clock in the morning they received tea with wheat bread, then about two o'clock in the afternoon the white of a hard-boiled hen's egg. One hour after the latter a sufficient quantity of the contents of the stomach was aspirated, and the estimation of the acid made. Then they had dinner, and about nine o'clock again had tea with wheat bread. About eleven o'clock they went to bed, were wakened about two o'clock and again received the white of egg. One hour later they were again wakened and the contents of the stomach aspirated. For the estimation of the free acid he employed Günzberg's reagent—an alcoholic solution of phloroglucine with vanilline, of whose utility he had previously convinced himself by numerous trials. His results are as follows: 1. The quantity of acid in the gastric juice is less at night than in the day. 2. The weakening of the acid reaction of the juice goes hand in hand with the weakening of the reaction for free hydrochloric acid. 3. Phloroglucine vanilline is an unusually accurate reagent for the free hydrochloric acid of the gastric juice.—*Deutsche med. Wochenschrift*, May 17, 1888.

Dry Mouth.

At the meeting of the Clinical Society of London, March 17, 1888, Dr. W. B. Haddon read a paper on dry mouth, or suppression of the salivary and buccal secretions. The patient was a woman, 65 years old, who had suffered from no affection which could throw light on her present condition. There was no history of family paralysis, or of the prolonged use of belladonna. Her mouth began to get dry some months previous to observation. The tongue was red, devoid of epithelium, cracked in all directions, like crocodile skin, and absolutely dry. The mouth generally was dry, and the mucous membrane smooth, shiny and pale, with a few patches of injection. There was also deficiency of moisture at the back of the pharynx. The tonsils were natural. The salivary glands, as far as could be made out, were natural in size. Common sensation of the inside of the mouth was unimpaired; but the sense of taste was retarded in consequence of the deficiency of moisture. When the mouth became moist later on, the saliva was found to be slightly acid, and to exert no action on a solution of starch. During this time the mouth had been getting dry, perspiration had notably diminished, and the lachrymal secretion was arrested. The patient received much benefit from the use of jaborandi. A case of similar nature under the care of Mr. Hutchinson was alluded to, and one under the care of Dr. Rowlands, of Liverpool, was communicated by the author of the paper. In conclusion, it was suggested that this condition of dry mouth was due to some disorder of the nervous apparatus. — *Lancet*, March 17, 1888.

Treatment of Varices by Ligature of the Internal Saphenous Vein.

After a brief review of the results obtained by Schee, Annandale, Madelung, Langenbeck, Fry and others, in extirpating varices, M. Ed. Schwartz details (*Rev. gén. de Clin. et de Ther.*, February 2, 1888), three cases in which he tied the saphenous vein at two or three different places, dividing it between ligatures, the indications being in one case a very painful varicose swelling at the inner border of the knee; in another, an extensive ulcer; in the third, great varicose enlargement of the leg. In the one just mentioned, the venous tumor, having become hard and firm from thrombosis, was enucleated three days after the ligation of the vein. Eight months later there was no serious return of trouble. The ulcer, which was two by two and a-half inches in size, and had persisted for six months, resisting other treatment, healed in eight days. Five months after operation, the cure remained complete. The third case did not report for observation, but the immediate result was a complete cure.

M. Schwartz believes with Langenbeck that these cases, as in the operative treatment of hernia, a long time must elapse before a radical cure can be claimed, but thinks it safe to say that the multiple antiseptic ligature of varices, and even their extirpation, when they form painful tumors, is strongly indicated, especially when the means usually adopted have proved ineffective and the patients are not much beyond middle age.—*American Journal of Medical Sciences*, April, 1888.

Instantaneous Cold.

The *Phar. Centralblatt*, 1887, p. 532, says that under this name a convenient substitute for outward application of ice is made by Boschlin, of Montpellier. It consists of felting made from cotton, jute, cotton-waste or China-grass, saturated with a mixture of several salts (nitrate of ammonium, chloride of ammonium, nitrate of potassium and sulphate of sodium) which upon being wet with water produces a low temperature.—*American Journal of Pharmacy*, April, 1888.

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THE DISEASE OF THE EMPEROR OF GERMANY.

After many vicissitudes of belief and statement it seems at last to be decided that the disease of the former Crown Prince, and late Emperor of Germany, was cancer of the larynx. This furnishes a sad confirmation of the opinion which we have always expressed in the REPORTER as to the nature of this malady, which has given rise, for the past year, to so much discussion. It is now asserted, or intimated, that Sir Morell Mackenzie has all along known that his patient had cancer of the larynx, and that he played the part of a wise and good man in concealing this fact from the world. This may be so; but the supposition would place in an unenviable light the man who could put to shame the best surgeons of Germany with a lie, and could treat so treacherously the enterprising medical journals in this and other countries which paid for his personal reports of the case, and confidently accepted and adopted his assurances that there was no sufficient evidence that the disease was cancer.

The dilemma between this and an error of diagnosis is an awkward and unfortunate one, indeed, and we cannot see much to choose between its two horns. Meanwhile, we feel as strongly as we have always felt that the straightforward course is generally the best one; and we shall feel this still more strongly, if it turns out—as it has been intimated that it may—that concealment of the nature of the Crown Prince's malady led to his mounting the Imperial Throne without authority of law, and involves the validity of every act he performed as Emperor.

RHEUMATIC PNEUMONIA.

In the *Lancet*, May 5, 1888, DR. W. B. CHEADLE has an interesting account of an outbreak of rheumatic pneumonia which occurred in St. Mary's Hospital, London. We gather from his paper that there was a series of six cases, four of which occurred in June and July, 1887, and the others soon afterwards, and that the symptoms were so similar in all the cases as to deserve special notice. In the first place, in every case except one the pneumonia followed an attack of pericarditis, which was itself a complication occurring in the course of the inflammatory rheumatism. In one patient, it is true, no pericarditis was noted; but, Dr. Cheadle very justly says: as the patient had twice before had attacks of rheumatic fever, the pericardium might have become adherent, and so no friction sounds have been produced; or the pericarditis may have existed before and been undetected. The patient died with double pneumonia, but unfortunately no autopsy could be obtained. Now, in the five cases in which the pneumonia followed an attack of pericarditis, it came on after a definite interval. This interval was, in two cases, six, and in two others, seven days after the first sign of pericarditis. In the remaining case the pericarditis existed fully developed at the time of the patient's admission, and the pneumonia appeared two days later, so that in all probability the length of the interval between the two complications was very near that known to have occurred in the others. It may be noted in passing, that in all of the six cases there was valvular disease of the heart; in four cases it was of long standing and of great gravity, while in the remaining two cases mitral regurgitation developed during the attack of rheumatism.

Not only was the time of appearance of the pneumonia peculiar, but it differed from ordinary pneumonia in its location and in its chief physical signs and symptoms. For example, it is well known that ordinary pneumonia is more common upon the right side than upon the left; but in the outbreak under discussion it invariably appeared first in, and chiefly affected, the lower lobe of the left lung. In three of the cases the right lung became similarly affected, but at a later date. Again, both cough and expectoration were entirely wanting. The pneumonia seemed to be fully formed when first discovered; even the crepitant râle of the initial stage was wanting in one case. It was recognized by the usual physical signs—dulness, blowing breathing, and increased vocal fremitus. Finally, the pneumonia which occurred in these cases differed from ordinary pneumonia in ending by lysis, not by crisis.

As these cases of rheumatic pneumonia occurred in patients who were in the hospital, and could therefore be closely observed, the cause to which Dr. Cheadle attributes the outbreak is entitled to much consideration. It is simply this: that the free ventilation in the wards of the hospital, made almost necessary by the extremely hot weather, had been sufficient to chill these rheumatic patients, who, as is well known, are peculiarly susceptible to cold. While it may be granted that draughts of air may have been the immediate occasion of the attacks of pneumonia, it is not too much to say that a predisposing cause of them may be recognized in the changed condition of the patient, a condition produced by the effect of the rheumatic poison on the blood. It is a significant fact that the pneumonia should have occurred in every case first on the left side; it is not improbable that the pleura became affected first by extension of inflammation from the pericardium, and that the inflammation of the lung tissue followed that of the pleura. In many of the cases which have been reported by other observers, there has been rather severe congestion, with undoubted apoplexy in some of the cases, as proved by the autopsy, than true pneumonic consolidation. But the cases here mentioned seem to have been true pneumonia, the cause of which, as we have already intimated, may have been the same as the cause of the rheumatism.

SACCHARINE.

This interesting chemical product, which attracted so much attention when its properties were first announced, has been the subject of continued investigation in order to determine whether or not it has any therapeutic value. The result of these investigations seems to indicate that it is to be regarded as a condiment rather than as a medicament.

An elaborate paper in the *Gazette Hebdomadaire*, May 18, 1888, by M. Charles Eloy, traces its history from the year 1879, when it was first isolated by Fahlberg, of New York, to the present time, and shows its physiological properties to be almost *nil*. It does not appear to modify any of the functions of animals to which it is administered, and it escapes from the body in the urine without interferring with any of its normal constituents. It, however, has a tendency to prevent fermentation, and to delay the metamorphosis of starch into glucose by the action of ptyaline or of pancreatine. Urine and feces containing saccharine do not ferment or become putrid as rapidly as those which are without it.

The hope that saccharine would prove of value in the management of *diabetes mellitus* has not yet been confirmed by experience; for in a number of cases it has soon excited disgust or given rise to symptoms of dyspepsia. It seems also, at times, to cause purgation. For this reason, saccharine must be used with discretion in cases of diabetes, and its use must be discontinued if it gives rise to gastric disturbance. If indigestion is a marked feature of diabetes, the use of saccharine seems to be absolutely contra-indicated.

In regard to its antiseptic properties, nothing of importance is yet decided. The natural hope that an antiseptic which is so largely eliminated from the body by the kidneys would prove of value in the treatment of cystitis, has not come to fruition as yet; and in no other respect has saccharine been shown to be superior to other and better

known antiseptics. As an addition to distasteful medicines the results obtained have also been disappointing; and there is some reason to fear that when added to sour wines, to sweeten them, it is to be regarded as an adulteration.

These conclusions in regard to saccharine need not be regarded as final; for further observation may reveal new ways in which it may be used in commerce or in medicine; but as yet it cannot be said to have won a very high position in either of these fields.

THE MANAGEMENT OF HOSPITALS FOR THE INSANE.

We alluded briefly, in our issue for June 9, to the action of the Pennsylvania Medical Society on the resolution of Dr. Hiram Corson to urge the State Legislature to separate the administrative control of the State Hospitals for the Insane from their medical management. This action seemed to be prompted by a feeling that a sort of of personal attack was intended upon the medical superintendents of three of the State Hospitals, and a desire to avoid the appearance of sanctioning such an attack. That no such personal attack was contemplated seems to be clear from the expressions of Dr. Corson and of those who share his opinions in regard to the principles involved in his resolution; but the medical superintendents who would be affected by its passage opposed it, because its animus might easily be misunderstood, and also because they do not share Dr. Corson's opinions in regard to the way in which hospitals for the insane should be managed.

After this resolution was disposed of, and at a subsequent meeting of the Society, another, of a thoroughly prudent character, was introduced by Dr. E. A. Wood, of Pittsburgh, calling for the appointment of a committee of thirteen, to include the medical superintendents of all the State Hospitals for the Insane, to investigate the question raised by Dr. Corson and to report to the Society. The resolution was adopted unanimously, and it is to be hoped that it will bring about a satisfactory solution of a very important question. Those who would regret to see any reflections cast upon the superintendents of the Warren, Danville and Harrisburg hospitals cannot but acknowledge that the question of separating the medical from the administrative functions of their superior officers is one which demands careful consideration, and that it ought to be decided without favor as well as without prejudice.

We have no doubt that the work of the committee representing the Pennsylvania Medical Society will go a great way toward determining this matter, and we expect that it will be of great service to the Legislature when they are next called upon to fix the slates of the medical officers of State hospitals for the insane.

ANTIPYRINE AND SEA-SICKNESS.

Not long ago there was an animated discussion at the Academy of Medicine of Paris introduced by a communication of M. Ossian Bonnet, who maintained that antipyrine was the best remedy for sea-sickness. A few days later M. Aubert suggested that the departure of the French delegates to the French Association for the Advancement of Science, to be held at Oran, Algeria, would be a very good occasion upon which to try the efficacy of the drug. We now learn from the *Bulletin Médical*, May 20, 1888, that M. Etienne Rollet, one of the Lyon internes, went with the delegates to Oran, and, not being attacked with sea-sickness himself, was able to study carefully what took place among his companions. It is amusing to learn that the passengers, who repaired in large numbers to the Congress, set sail at four o'clock in the afternoon, and at six o'clock, when at least sixty had taken antipyrine, only four remained at table to finish their dinner! This was as true of those who took the antipyrine two or three days before embarking, as of those who deferred taking it until their arrival on board the vessel. On the return from Oran, M. Rollet was able to prove that antipyrine has no action upon sea-sickness. As an impartial observer he concluded that antipyrine could not be counted on, when administered by the stomach in the usual

doses, either as a means of treatment during the attack or as a preventive of sea-sickness.

If M. Rollet's opinion is confirmed by subsequent observers, no more can be said than that antipyrine has failed where almost every drug in the pharmacopœia had been tried and found ineffectual. We may still hope that antipyrine will prove useful in some cases in which other drugs have failed, and come to be counted as one of the drugs which may with propriety be tried in the treatment of sea-sickness. The susceptiblity of different persons to this disorder varies so widely, and the reasons for this variation are so little understood, that it is not to be expected that any one drug will be be found equally serviceable in all cases.

NEPHRECTOMY.

The papers and discussions at the recent meeting of the Pennsylvania State Medical Society on the subject of nephrectomy were of the greatest interest and value. The paper of Dr. John B. Deaver, published in the last number of the REPORTER, lays down clearly the indications for this operation in cases in which the kidney is the seat of morbid growths, and the demonstration, by Dr. Mordecai Price, of a case in which he successfully removed the right kidney for a pistol-shot wound passing through the liver and into it, was a most striking proof of what can be accomplished by courageous and discreet surgery.

An operation which has now been performed more than four hundred times cannot be said to be any longer on trial; and it seems to be clear that the successful performance of it may be regarded as a question of skill in diagnosis and dexterity in practice.

Fortunately for surgeons and for mankind, the matter of diagnosis is not usually obscure in cases of penetrating wounds of the abdomen, and a laparotomy, if properly executed, is a certain and far from dangerous means of clearing it up. In regard to morbid growths, a careful study of Dr. Deaver's paper will show that a diagnosis of their seat and nature—so far as the kidneys are concerned—is not so difficult as one might suppose, and the question as to the propriety of nephrectomy is not hard to decide. There may be surgeons who would operate more freely than Dr. Deaver advises, but we think it may be said to be quite safe to follow the rule which he has laid down.

WASHING OUT THE STOMACH AFTER OPERATIONS UPON THE MOUTH.

At the recent meeting of the Pennsylvania Medical Society, Dr. Goodwillie, of New York, made, by invitation, some very interesting remarks in regard to his mode of operating for the cure of hare-lip. In the course of these remarks he stated that it is his custom to wash the stomach out after operating, in order to empty it of the blood which often enters it during operations of this kind. This procedure, as he described it, is simple and easy to execute, and not only frees the stomach of a useless burden, but very materially lessens the probability that vomiting will occur. As vomiting after operations upon the mouth is a very disagreeable occurrence, and endangers the success of what has been attempted, it must be regarded as a decided advantage to prevent it, and the method used by Dr. Goodwillie deserves the careful consideration of all surgeons.

SMOKERS' VERTIGO.

At a meeting of the *Academie de Médicine*, May 15, 1888, M. Lagneau read a report upon a communication made a month before by Dr. Decaisne upon the vertigo observed in smokers. While confirming the general opinion that excessive smoking may give rise to vertigo attributable to tobacco, M. Lagneau called attention to the fact that vertigo due to congestion of the brain may be confused with tobacco vertigo, if it occurs in the person of a smoker.

As most medical men are addicted to smoking, it may give them some comfort to think, when their heads swim, that this is not caused by their indulgence, but chargeable to over work. Still, if they overwork themselves at the right end of a pipe or cigar, we would suggest that a little rest at this point might relieve the congestion which annoys them. This sort of rest-cure is worthy of a trial.

Book Reviews.

[Any book reviewed in these columns may be obtained, upon receipt of price, from the office of the Reporter.]

DISSOLUTION AND EVOLUTION, AND THE SCIENCE OF MEDICINE, Etc. By C. Pitfield Mitchell, member of the Royal College of Surgeons, England, etc. 8vo, pp. xiv, 246. London: Longmans, Green & Co., 1888. Price, Sixteen shillings.

This book contains an attempt to disseminate some new applications of Mr. Herbert Spencer's leading generalizations, especially as applied to the study of pathology. The style of the book may be inferred from the opening sentence: "Dissolution is a disintegration of matter and concomitant absorption of motion, during which the matter passes from a definite coherent heterogeneity to an indefinite, incoherent homogeneity, and during which the retained motion undergoes a parallel transformation."

The following study is of the most abstruse and perplexing character, and while it may attract a few men familiar with the terms and style of Mr. Spencer's works, we doubt that many of our readers will care to go quite through it. The argument leads up to certain so-called "practical deductions and conclusions." These, we regret to say, strike us as lame and impotent, and we lay the book aside with a sense of regret that so much energy should have been spent in preparing a treatise which must confuse, if it does not confound, those who look to it for light. The publishers' part in making this book has been very well done, but we can hardly forgive them for bringing it out without an index.

Pamphlet Notices.

[Any Reader of the Reporter who desires a copy of a pamphlet noticed in these columns will doubtless secure it by addressing the author with a request *stating where the notice was seen* and enclosing a postage stamp.]

State Protection Against Quackery. By Charles F. J. Lehlbach, M. D. The President's Address at the 72d Annual Meeting of the Essex District Medical Society, held at Newark, N. J., April 3, 1888. 19 pp.

Report of Proceedings of the Illinois State Board of Health. Quarterly Meeting. Chicago, April 19–20, 1888. 13 pp.

Migraine in Childhood. By Wharton Sinkler, M. D. From the Transactions of the Philadelphia County Medical Society, October 12, 1887. 8 pp.

The Legal Aspect of Suicide. Annual address before the Medical Judisprudence Society of Philadelphia, January 10, 1888. By Hon. Wm. N. Ashman, President of the Society. Published by the Society. 6 pp.

—Dr. Lehlbach's address is most attractively written, and describes the unsatisfactory conditions of medical practice in New Jersey, where any sort of a diploma carries with it the right to practice. Dr. Lehlbach very truly says that it is a mistake for the community to demand that medical men shall carry out some scheme to protect it from the dangers of quackery; and puts the responsibility where it belongs, namely: on the State. Still, like other public spirited physicians all over the land, he urges a plan which ought to require no urging from doctors, and gives his voice in favor of the establishment of a State Board of Examiners.

—One of the most interesting subjects considered in the report of the Illinois Board of Health—which is an excellent bulletin of its proceedings, strictly scientific and unpretentious—concerns the "Wear and Tear of the Medical Profession." Studying the facts in regard to about 14,000 physicians in Illinois, Dr. Rauch makes the annual death rate for ten years just passed to be about 13.3 per 1000. The annual death rate among physicians, for the first few years after entering practice, is lower than that for all males living in the State; between the ages of 40 and 60 years it is higher; and after this it becomes progressively lower up to the age of 80 years, after which it is enormously higher. The inferences to be drawn from the table presented in this report are exceedingly interesting, one of them being that a very large number of physicians must live longer than 80 years.

—Dr. Sinkler calls attention to the frequent occurrence, and the importance, of migraine in childhood. He points out the influence of heredity in producing it, and of poor food and air, loss of sleep and eye-strain in provoking it. The treatment suggested is indicated partly by its cause, and consists in securing good nutrition with as sparing a use of medicine as possible.

—Judge Ashman's address on suicide is of the most interesting and instructive character. It defines the legal view of suicide as it could be defined only by one learned in the law and skilled in saying what he means. It contains some very curious statements as to the way in which the law regards and treats those who succeed in the act of suicide or fail in the attempt, as well as those who prompt or aid it. The relation of insanity to attempts at suicide is briefly alluded to; and the author goes further than Prof. Reese, who denies that suicide is an evidence of sanity; for Judge Ashman thinks it is sometimes an evidence of unusually cool and deliberate reasoning. For the other interesting matter of this address, we must refer our readers to the pamphlet itself, which we promise them will amply repay them for the effort to secure a copy.

—Dr. Semeleder, of Mexico, writes to the *Medical Record*, April 7, 1888: "A man, forty-five years old, suffering from pneumonia, was treated by the dosimetric method, the following being one of his prescriptions, the figures representing granules to be taken at a dose. Bromocamphor, 8; quinine hydrobromate, 4; arbutine, 1; strychnine hypophosphate, 1; aconite, 1; veratrine, 1; digitaline, 1; sodium benzoate, 1; iodoform, 1; helenine, 1; musk 1. These were to be taken once in every two hours, that is to say, a new medicine every ten minutes. In addition, two granules of quassine were given every time the patient took any nourishment. He took an average of three hundred granules a day, or three thousand in the course of ten days; when he died. The cost of medication for this period was $45."

Correspondence.

Veratrum Viride.

Editor Med. and Surg. Reporter:

Sir:—I am constrained to believe, from experience, that the profession have not entirely given veratrum viride its broadest position in the field of therapeutics. In acute pneumonia, a disease in which it is used most, I am inclined to think that its seemingly good effect of toning down the pulse, acts only as a mask for the subsequent heart failure induced by its administration. Indeed, I have been induced to believe that this drug is of little avail in any acute inflammatory affection. But it is in chronic blood diseases where veratrum viride wields its most beneficent influence as a remedy. Among these, syphilis offers a broad field for its action. If the disease is in its incipiency I usually give hyd. chlor. mite in one or two grain doses for about a week, and then stop it. I next order the patient to take Norwood's tincture veratrum viride, five drops ter die, immediately after eating, in water, for one week, when the night dose is increased one drop every night until the dose of ten drops is reached. I then keep the patient taking five drops after breakfast and dinner, and ten drops after supper, until the disease is expelled from the system. As adjuvants in the treatment I order the bowels to be kept open with saline aperients, the skin to be kept acting by a daily bath, and if there are chancres I either use iodoform liniment or calomel and iodoform powders in equal parts, applied three times per day. The use of alcoholic stimulants is strictly interdicted. In scrofulosis the drug is equally as efficacious. The treatment is about the same as in syphilis, except that there is no mercury used, and a good emulsion of cod-liver oil is employed and given with the veratrum. All glandular enlargements in scrofula, and buboes in syphilis are rapidly absorbed, and syphilitic laryngitis quickly relieved by veratrum. Syphilitic ophthalmia also shows its virtues by the rapid reduction and extinction of all inflammatory action, so soon as the system gets well under the alterative influence of the remedy.

The efficacy of veratrum in puerperal fever has, in recent years, been brought to the notice of the profession. I will add here, however, that the reflex influence upon the brain, and the detergent effect upon the circulatory system, of croton oil, administered in two drop doses until the bowels respond well to its action, greatly assists veratrum in controlling puerperal convulsions.

Yours truly, A. H. Byrd, M.D.

Burton's Hill, Ala., June 4, 1888.

Treatment of Wounds of the Palmar Arch.

Editor Med. and Surg. Reporter:

Sir:—Your editorial of June 2 recalls a case of mine in the summer of 1886. A young man came to my office with his hand wrapped in cloth soaked in blood, and from which the hemorrhage still continued very profusely. Upon taking off the bandages, I found a wound in the palm two inches in length extending entirely through all the tissues to the metacarpal bones, and from which the divided ends of three tendons protruded. I was unable to ligate the bleeding vessels, and after a discouragingly painful effort to stop the hemorrhage in that way, I soaked cotton in solution of alum, pressed it directly into the gaping wound, and securely binding it on, slung the arm up, and left it. I was very anxious about the results, as I had never seen anything of the kind recommended. The wound progressed very favorably; nothing occurred to prevent an excellent union of all parts. Should I have another case in which torn arteries in the palm of the hand could not be *easily* reached, I shall again use compression, as I deem it less painful and conducive to as good results as ligation in the palm, and while not as favorable for an exhibition of surgical implements and surgical skill (as regards cutting), as the wrist operation, it helps much to establish conservative surgery, from which the desire to cut naturally tends. Yours,

H. L. Manchester, M.D.

Pawlett, Vt.,
June 6, 1888.

Blue Gum Negroes.

Editor Med. and Surg. Reporter:

Sir:—About two years ago, in the vicinity of Como, Miss., Mr. Douglas Durrett became involved in a difficulty with a *blue gum* negro, by whom he was bitten upon the hand. Inflammation and suppuration of the hand and arm ensued, from the effects of which he died in about ten days; the poisonous nature of the wound being attributed to the peculiar color of the the negro's gums. Others of the neighborhood were reminded of a similar instance which had come within their observation. And about May 1, near Victoria, Miss., Mr. William Cannon, while engaged in a fight with a *blue gum* negro, was bitten on the hand, and came near losing his life. The

newspaper in writing up the occurrence, stated that one of the medical attendants had never "heard of such a thing;" and another had only heard of two cases up North—reported, I suppose, by the Northern press.

Unable to recall any allusion in medical literature to the fact that the bite of persons possessing blue gums (no race, save the negro, has) is peculiarly poisonous, I write for light on the subject; and shall be glad to hear from you, or any other member of the profession. There being a *shadow* of foundation for such a belief, if by investigation the fact can be established beyond question, why should not our legislatures make the biting of another by an individual having *blue gums* something more of an offense than a mere *assault?*

Yours truly, A. A. YOUNG, M.D.
Clear Water Harbor, Fla.,
May 31, 1888.

Brother Come's Caustic Balsam.

EDITOR MED. AND SURG. REPORTER:

Sir:—Will the Editor, or some one of its contributors, give to the readers of the REPORTER, the receipt for Come Bros. Caustic Balm mentioned on page 538, April 28, 1888, and oblige.

Yours truly, SUBSCRIBER.
Wysox, Pa.
May 15, 1888.

EDITOR MED. AND SURG. REPORTER:

Sir:—In reply to yours of May 17, the following is the formula for Brother Come's caustic balsam, and the manner of using it:

℞ Arsenic. alb. (white arsenic)....1 gramme
Hydrarg. sulphuret. rubrum .....5 grammes
Spongia usta (calcinated sponge) 2 grammes
M.—Pulverize.

At the time of using it, water is added to this powder until it has the consistence of cream; it is then lightly applied with a brush on the ulcerated surfaces, taking care to use only a small quantity. It is better to apply it at different times at several days' interval, than to apply a great deal of it at once.

It is then covered with a piece of adhesive plaster, and kept in place until the eschar drops away, which occurs from the 10th to the 30th day.

If the ulcerated surface is very large, the treatment must be divided; not more than three square centimeters must be treated at once, on account of the danger of absorption; and a new portion must be cauterized only when the preceding eschar has fallen off.

If at the periphery of the ulcer there are dried tissues, these must be refreshened, for the caustic will act only on fresh or wet tissues.

Yours truly,
ARTHUR C. HUGENSCHMIDT, M.D.
Paris, France,
May 29, 1888.

NOTES AND COMMENTS.

Insoluble Pencils for the Urethra.

The *Monatshefte für prakt. Dermatologie* No. 5, 1888, states that in ulcerations and inflammations situated in the anterior portion of the urethra, or at the meatus, in which healing is rendered extremely difficult through the contact of the diseased parts with urine and the reinfection thus brought about, antiseptic pencils are of great service. Formulæ hitherto employed result in the common fault that the pencils are too brittle, can be moulded only with difficulty, and dissolve too quickly at the temperature of the body. The following formula is recommended:

℞ Olei theobromæ..... gr. xc
Ceræ albæ.....gr. lxxv
Acidi borici (*vel* iodoformi)....gr. xxx
Zinci oxidi.....gr. xv
Tragacanthæ. .....gr. lx
M. ft. bacilli elastici.

These pencils can be made of any desired length or thickness, and for ease of introduction of a conical form. They keep the walls of the urethra separated, for they do not disappear for hours. They should not be used when, as in obstinate catarrh of the bladder, a powerful stream of urine is necessary to expel them.—*Allgemeine med. Central-Zeitung*, March 14, 1888.

Menstrual Bleeding from a Laparotomy Scar.

At a recent meeting of the Kiev Obstetrical and Gynecological Society, Professor Georg E. Rein showed (*Vratch*, No. 7, 1888, p. 136), a menstruating woman from whom he had about three years before removed a cyst of the right ovary weighing thirty-seven pounds, fixing the pedicle in the abdominal wound. The patient soon recovered, and the wound healed, but at one part of the scar there remained a diminutive slough, which fell off just before the beginning of menstruation, its separation being followed by a constant flow of blood from the denuded surface during the whole catamenial period. The phenomenon had regularly recurred monthly ever since. As a rule, the scar begins to bleed somewhat earlier than the uterine flow makes its appearance. The

menstrual blood from the cicatrix has a characteristic odor. It is difficult to explain such an occurrence. Possibly a Fallopian tube or one of the uterine cornua had been stitched together with the pedicle into the abdominal wound. However, Professor Rein hopes soon to ascertain the nature of this interesting and rare case, since the patient must undergo a second laparotomy for disease of the left ovary.—*British Med. Journal*, March 31, 1888.

Suggestion as to the Cure of Goitre.

French army surgeons have been profitably employed in drawing up medico-geographical reports of the French Departments. Surgeon-Major Aubert has already reported to the Académie de Médecine on Calvados, Loire-Inférieure, and La Vendée. On February 14, his report on the Medical Geography of the Ain was read. In reference to ninety-three men with goitre from the mountainous districts of that department, who were exempted from military service from 1872 to 1886, Dr. Aubert makes a most reasonable suggestion. As most cases of goitre between the ages of 18 and 20 are curable, a great service would be done to them by enrolling, instead of rejecting them, and placing them in the territorial army in healthier parts of France, particularly in coast stations. By sending these men far from their mountains to naval arsenals they might be permanently cured, and at least could not fail to derive great benefit from the change. —*British Medical Journal*, March 31, 1888.

Aromatic Vinegar.

The *American Druggist* gives the following as Dieterich's formula:

Tincture of benzoin	1 fl. oz.
Alcohol	1⅛ " "
Acetic Ether	1½ " "
Extract of jasmin	1½ " "
Acetic acid	3½ " "
Oil of rose	10 drops
Oil of Neroli	5 "
Oil of wintergreen	5 "

The Microbe of Infectious Endocarditis.

The *Gazette Hebdomadaire*, April 13, 1888, states that at a recent meeting of the *Société de Biologie* of Paris, M. Gibert announced that he had, in conjunction with M. Lion, cultivated a microbe found in a patient who had died of infectious endocarditis. The blood and the vegetation in the heart yielded the same microbe and only this one. When this was inoculated in rabbits it produced vegetative endocarditis without there having been previous valvular lesion.

Hydrophobia at Rio Janeiro.

A Pasteur Institute has been founded in the capitol of Brazil. In the reception-room for patients, there is hung a splendid photograph of Edelsfeldt's large picture, exhibited in Paris at the Salon, in 1886. It represents Pasteur in his laboratory, observing an inoculated marrow in a bottle. The Institute was inaugurated with great solemnity in the presence of the Ministers and most of the medical corps of Rio.

Novel Extension of the Uses of Cocaine.

Under this title Mr. E. Hurry Fenwick, in a communication to the *Lancet*, May 5, 1888, relates some remarkable experiences in the use of injections into the urethra of strong solutions of cocaine, for the purpose of relieving subacute pains remote in situation from the urethra. After citing several cases in which there was pain of a neuralgic or muscular character, he concludes that if pain in any part of the body be due to a *slight* nerve irritation of an unimportant character, a cocaine injection will rapidly relieve it; whereas, if the pain is due to a severe nerve irritation, a cocaine injection will not relieve it. He has applied cocaine in this way for the determination of the presence of organic or functional disease of the kidney, and has several times been able to verify his diagnosis through the patient's subsequently passing a small stone. He employs a 20 per cent. solution in water, and injects twenty or thirty drops.

Creasote in Chronic Affections of the Lungs in Children.

In the fiftieth report of the Wilhelm-Augusta Hospital at Breslau, Prof. Soltmann communicates the results of the treatment of chronic lung affections of children with creasote. He employed it in cases in which there were slight or progressive disturbances, without regard to the presence or absence of bacilli. The creasote was given to children in doses of from two to seven drops a day, while to adults, three, six or ten drops were ordered. His prescription is as follows:

Creosoti	gtt. iv–xiv
Sp. ætheris	gtt. vi–xij
Aquæ destill.	f℥iss
Sacch. albæ	gr. cl

M. Sig.—Teaspoonful every two hours.

The creasote was admirably borne without exception by all the children, and taken without resistance. Pain in the stomach, nausea, vomiting and diarrhœa never occurred, even when there was high fever. It is

noteworthy that in almost all cases the appetite increased, that the patients gained in weight with striking rapidity, their appearance became blooming, the cough and expectoration diminished, and gradually the symptoms of disease of the lungs disappeared.—*Wiener med. Presse*, April 22, 1888.

Influence of Salt upon the Secretion of the Stomach.

N. Reichmann publishes a communication in *Archiv für exper. Pathol. und Phar.*, Bd. XXIV, upon an experimental investigation concerning the local influence of salt upon the secretion of the stomach. By giving it when the stomach was empty, and before and after a test meal, he was able to determine that so far from increasing the secretion of gastric juice, it actually hinders it. The diminution of the acidity of the gastric juice, as was always proved after the introduction of sodium chloride, arises chiefly through transudation from the vessels of the mucous membrane, which is irritated by the salt; but the transudate is alkaline and neutralizes the hydrochloric acid.—*Deutsche med. Wochenschrift*, May 17, 1888.

Sulphonal.

In the *Berliner klin. Wochenschrift*, April 23, 1888, Rabbas communicates the results of his trials of sulphonal in the clinic for mental and nervous diseases at Marburg. He used the drug two hundred and twenty times upon a total of twenty-seven patients who were affected with different diseases. It was given in a wine-glassful of water. If any of the powder remained behind, it was washed down with water. Even the most excited patients offered scarcely any resistance to the taking of the medicine. Rabbas's conclusions are as follows: Sulphonal is a hypnotic which in moderate doses (30 to 45 grains) acts better and with more certainty than amylene hydrate and paraldehyde do in larger doses. Even in persons who are accustomed to narcotics its effect is successful. It is preferable to both the drugs just mentioned in respect to taste and odor. Chloral hydrate, it is true, produces sleep sooner, but its effect is not so continuous as that of sulphonal. Single doses of 30 or 45 grains usually produce a good effect in excited patients. When its administration has been continued for some time, an increase in the dose does not seem to be necessary. Sleep occurs for the most part in half an hour, more rarely in one or two hours and lasts uninterruptedly from six to eight hours or more; the sleep is entirely normal. Large doses, 60 grains, varying at short intervals with smaller doses of 30 and 45 grains, exercise no injurious influence upon the organism. In general, bad secondary effects do not occur even when the drug is given for a long time. Its absolute harmlessness as regards its action upon the heart, even when used a long time, makes it greatly preferable to chloral, the weakening effect of which upon the heart is generally known and dreaded. In a few cases sulphonal has failed.

Myxœdema and the Thyroid Gland.

At the meeting of the Clinical Society of London, May 25, Dr. Ord reported for the committee on myxœdema, appointed by the Society, the result of their investigation. These results are stated in the *Lancet*, June 2, 1888, in fourteen propositions. Without attempting to quote these at length, it may be said that the committee regards the presence of the thyroid body as absolutely essential, if there is to be no myxœdema, sporadic cretinism, or cachexia strumipriva. Complete removal or destruction of the thyroid gland, or loss of all its functions from any kind of disease, can, must and does cause myxœdema or its equivalent. If there is abolition of the thyroidic functions during early life, cretinism results; whereas, if the thyroid is slowly destroyed after puberty has been reached, myxœdema results. For the most part the destruction of the thyroid appears to be due to the growth of fibrous tissue in the organ, arresting its functions, and destroying its proper glandular tissue. It was stated by the committee that such a growth of fibrous tissue occurs in other parts of the body in cases of myxœdema.

National Association of Railway Surgeons.

The Committee for making arrangements for a National Meeting of Railway Surgeons, decided to hold the meeting in the City of Chicago in parlor O of the Palmer House, on the 28th day of June, at 9.30 A.M. It is desired that all railway surgeons attend this meeting and assist in organizing this National Association. Every surgeon who is in the employ of any railway company is invited to this meeting.

Monument to Pirogoff.

There is a movement in medical circles in Russia to erect a monument in St. Petersburg or Moscow to Pirogoff, the famous surgeon. The funds for this monument are to be raised by a general subscription throughout the whole Russian Empire.

Autopsy on the Emperor of Germany.

Telegraphic reports to the daily papers state that the post-mortem examination made upon the late Emperor of Germany was confined to a dissection of the neck, larynx and lungs. The larynx was found to have been destroyed by suppuration, and in its place was a cavity about the size of a clenched fist. Dr. Mackenzie is said to have stated that the disease was beyond doubt cancer of the larynx. He adds that the diagnosis was rendered very difficult, as the disease attacked the cartilages of the larynx at the outset, and afterwards developed chiefly in the lower part of the larynx.

A somewhat different account states that in addition to the destruction of the larynx putrid bronchitis also existed, as the result of inspiration of putrescent particles into the bronchial tubes. The whole larynx is said to have been in a state of suppuration, presenting a soft, lumpy mass, with scarcely any trace of cartilaginous structure remaining. There was nothing to show the existence of perforation of the walls separating the trachea and œsophagus. The choking sensation from which the Emperor suffered during the last days of his life, which was attributed to such perforation, appears to have been really due to collapse of the larynx, owing to the destruction of the cartilage.

Warner and Warner.

It is somewhat surprising to find in the *Centralblatt für Chirurgie*, May 26—one of the most esteemed medical journals of Germany—an advertisement of "Warner's Safe Cure," which asserts that the remedy is already much used by physicians in their practice, that there is a depot for its sale at Frankfort-on-the-Main, and that specimen bottles will be sent free to all physicians who wish it.

It is curious that this happens just at a time when William R. Warner & Co. of this city have felt called upon to deny as calumnious, the charge or imputation that they are the makers of this preparation. In this country, the articles made and sold by Mr. Warner, of Philadelphia, are on a very different footing from the much advertised "safe cures;" and we do not wonder that he is indignant to have it intimated that he is the maker of the latter. If our German cousins knew how the "safe cures" are regarded by the medical profession here, they would hardly find such a welcome as is indicated by the advertisement we have referred to. There may be some confusion abroad in regard to the different Warners; but we think there is no confusion in regard to them here.

Hydrastis Canadensis.

Dr. Thomas Oliver, in a communication to the *Lancet*, May 5, 1888, upon clinical experience of some of the more recently introduced drugs, says of hydrastis that it certainly does restrain the flow of blood in myofibromata, but that it is in cases of menorrhagia, in which loss of blood depends upon a para- or a peri-metritis, that its efficacy is most marked. It not only relieves ovarian pain, but it has checked uterine hemorrhage in cases in which there has been such evidence of inflammation outside and immediately around the uterus, that intra-uterine medication could not have been attempted. The drug has, in his hands, had little if any effect upon uterine hemorrhage dependent upon mucous polypi. It soothes ovarian pain, acute or chronic, and checks the bleeding in the latter; it checks the bleeding of endometritis, and relieves that unpleasant pain which prevents the woman thus affected from either sitting or walking; it relieves, and in many cases, he says, has arrested the hemorrhage due to puerperal metritis and chronic peritonitis; and in many instances it has relieved the headache so frequently complained of by women who are the subjects of chronic inflammatory affections in and around the uterus and ovaries.

In cases of pelvic peritonitis, associated with ovarian pain and uterine hemorrhage, the combination of hydrastis and salix nigra, he says, has proved of signal service. Further, in the highly nervous condition into which some women are so frequently thrown soon after the climacteric, salix nigra and hydrastis canadensis in combination, have answered well.

Suicides in London and New York.

The *Lancet*, June 2, 1888, from an examination of the statistics of suicides occurring in New York and in London, concludes that in New York suicide is, generally speaking, committed at an earlier age than in London. It admits, however, that this may be due to the much larger foreign element in New York as compared with London, as there is good reason, it says, for believing that an examination of the ages at which suicides are committed in Continental Europe would show that suicides take place there at an earlier age than they do in England.

Rachitis.

Schwarz (*Medizinische Jahrbücher*, 1887), has demonstrated, by an examination of 500 children within an hour after birth, at the lying-in hospital in Vienna, that the signs of rachitis can usually be found at that early period, showing the disease to be, at least usually, intra-uterine in its commencement. To a very large extent he confirms the usual impressions regarding etiology and pathology. Of the 500 children examined, 97 were without sign of this disease, 188 had well marked rachitic rosaries, together with rachitic changes of the cranial bones, varying from an abnormal weakness along the borders of the sagittal suture to an almost complete defect of ossification of the cranium; 155 had well marked rachitic rosaries without the changes in the cranial bones; 36 had the changes in the cranial bones alone, and 24 presented only slight swellings at the union of the bones and cartilages of the ribs. Of the children born in the seventh lunar month, 14 were rachitic, 1 normal; in the eighth lunar month, 27 rachitic, 4 normal; in the ninth lunar month, 50 rachitic, 12 normal. Fifteen of the mothers of rachitic children presented signs of having suffered from a high grade of rachitis. Of six cases of twins, in three one child was normal, while the other was rachitic; in the others both children were rachitic. His conclusion is that every child should be examined as soon after birth as practicable, and, if any signs of rachitis are found to be present, active treatment should be immediately instituted.—*N. Y. Medical Journal*, March 31, 1888.

The Incompatibility of Antiseptics.

Dr. Boxall calls attention to a very important point in connection with the employment of mixed antiseptics. He has ascertained that mixtures of corrosive sublimate and iodine, iodine with carbolic acid, and carbolic acid and olive oil, produce chemical changes which materially affect the properties of the original constituents. He found, moreover, that soap and glycerine are, as a rule, bad vehicles for antiseptics. Perchloride of mercury, iodine, salicylic acid, and permanganate of potassium are changed or precipitated by admixture with soap. It is evident, therefore, that some little discrimination is necessary before we employ other than simple solutions of the principal antiseptics.—*Medical Press and Circular*, May 2, 1888.

Purpura Hemorrhagica after a Mental Shock.

Dr. Ed. de Smet, of Brussels, has recently had a case in which a young woman of a highly nervous temperament, in consequence of a severe fright, experienced an eruption of purpura hemorrhagica, though she had never had any eruption of the kind before. Some four months subsequently, however, in consequence of a fall, a similar eruption made its appearance. The treatment was directed mainly to the nervous system, which had evidently been very much affected. The author refers to M. Lenoir, of Lille, who has published cases of various skin diseases—eczema, psoriasis, herpes, pemphigus, and vitiligo—which have followed a mental shock.—*Lancet*, March 17, 1888.

Antiseptic Ammunition.

A useful suggestion is just being carried out by the Netherland Government, by which provision will be made for supplying each soldier, during the time of war, with a cartridge containing some antiseptic dressings. Each cartridge will be made of convenient size, namely about ten centimetres in length, by five in width, and will be secured at one end with a safety pin. The dressings contained in each will consist of a bandage, about three metres long, and two pieces of gauze, all of which have been rendered antiseptic by a sublimate solution. Hence, in the event of wounds being received a ready means would be at hand for the immediate application of antiseptic dressings. Soldiers, in the case of slight injuries, would probably at once avail themselves of the dressings, and the latter could not fail to be of much use to the surgeons. The idea is well worthy of the attention of the military authorities in this country, and might even with advantage be adopted, as it has been for years past in the German army. In the wars in which, during the past few years, we have been engaged in tropical climates, the early application of antiseptics to the wounds received by the men was admitted to be a matter of the utmost importance by the army medical officers attached to the forces.—*Medical Press and Circular*, May 9, 1888.

Accident from the Explosion of Chlorate of Potassium Tablets.

The *Canada Pharmaceutical Journal*, June, 1888, says: A prominent tenor of this city was lately engaged to sing at the opening ceremony of one of our churches, and feeling somewhat hoarse, supplied himself with

some tablets of chlorate of potassium, which he put into his pocket, which also contained matches. Just before the critical moment of the performance he had recourse to the remedy, and, fumbling hastily in his pocket, produced friction sufficient to initiate an interesting reaction, which is, however, more adapted to the chemical lecture desk than the platform of the vocalist. The result was striking and produced a decided sensation, and though it was at first feared that the singer had lost several important vital organs, it was found on investigation that he escaped with some damage to his clothing, and a very severe burn on his hand.

Treatment of Penetrating Gun-Shot Wounds of the Cranium.

Dr. Joseph D. Bryant, in a paper read before the Medical Society of the State of New York (*N. Y. Med. Journal*, May 5, 1888) concludes that:

1. A bullet should be removed from the brain as soon after its reception as its situation can be determined and the patient's condition will permit.

2. A bullet should be removed from the brain at a later period if symptoms supervene and it can be located.

3. A bullet that has been located in the brain and has not been removed, should be removed before the supervention of symptoms, when it assumes a migratory character.

4. No effort should be made to remove a ball from the brain if it cannot be located.

Pigmentations in Pregnancy.

The *Journal of Cutaneous and Genito-Urinary Diseases*, May, 1888, says Dr. Monin recommends the following:

℞ Cocoa butter,
Castor-oil āā ..... ℥iiss
Oxide of zinc..... gr. v
White precipitate..... gr. ij
Essence of rose..... gr. ij–x

M. S.—Apply morning and night.

—The bill abolishing hanging for all murders committed after January 1, 1889, and providing that the execution in New York shall be carried out by the use of electricity, was signed June 4 by Governor Hill. The bill further provides that the court delivering the sentence shall name merely the week within which the execution shall take place, the day of execution being left to the discretion of the principal prison officer.

NEWS.

Dr. Mark Hovell threatens to sue the London *Times* for publishing assertions with reference to his action in the case of the late Emperor of Germany, which are regarded by Dr. Hovell as libellous.

—Some of the Dublin Hospitals are to receive large sums of money from the estate of the late Mr. William Bannon. The amount which each of the favored hospitals will receive has been estimated at thirty thousand dollars.

—Dr. Paul F. Mundé will give the lectures on Gynecology before the Dartmouth Medical College this year, and Dr. William H. Parish those on Obstetrics. The vacancy caused by Dr. Dunster's death has not yet been filled.

—The French Academy of Sciences is interested in regard to the recent discovery of a sulphurous mineral water in the very heart of Paris. While digging for the foundations of a hospital building on the Ile Saint-Louis, sulphurous springs were found at a depth of about 35 feet from the surface.

—The *Deutsche med. Wochenschrift*, April 12, 1888, informs its readers that it has been discovered that "Gleditschine" is a mixture of atropine and cocaine! If the Germans had been using this now long-exploded mixture, they would no doubt have found out sooner that it had but a brief day in America.

—The faculty of Harvard Medical College has recommended the following appointments to the Board of Overseers: Dr. Frederick I. Knight to be Professor of Laryngology; Dr. William H. Baker to be Professor of Gynecology, and Dr. Clarence J. Blake and Dr. J. Orne Green to be Professors of Otology and Clinical Otology.

—The Philadelphia *Ledger*, May 28, 1888, says: "Rev. Dr. Newman, the newly elected M. E. Bishop—Dr. Lawrence, a noted spiritualist declares—was once persuaded to try for a serious ailment a remedy which was obtained by spiritualistic mediumship, and was cured by it. None genuine unless the name of the medium is blown on the bottle."

—A Chest and Throat Dispensary has been inaugurated at 411 Spruce Street, this city, under the auspices of the city mission of the Protestant Episcopal Church. Drs. F. P. Henry, Thos. J. Mays and Wm. M. Angney constitute the medical staff of the Chest Department, and Drs. A. W. Watson and C. Jay Seltzer that of the Throat Department.

—Basing his statement on an exhaustive study of official documents, M. Marambat stated, at a recent meeting of the Academy of Medicine of Paris, that the increase in crime is in a large measure due to the use, or rather the abuse of spirits. He has been enabled to obtain positive data in the case of 3,000 prisoners, among whom there were 2,124 confirmed inebriates: a proportion of 72 per cent.

—The Pennsylvania State Dental Society held its annual session in Philadelphia, June 7, at the College of Physicians. A number of interesting papers were read, and an animated discussion was held as to the admission of visiting members of the medical and dental professions to the meetings, and upon a majority vote to take part in the discussions. The motion was made by Dr. Truman, but was finally voted down.

—At the competitive examination held by the Board of Charities and Correction to select a successor to Miss Fisher as head of the Training School for Nurses at the Philadelphia Hospital, Miss Marian E. Smith was the successful candidate. Miss Smith was formerly one of Miss Fisher's assistants at the Philadelphia Hospital, which she left in order to accept the position of Superintendent of the Training School at the Pennsylvania Hospital.

HUMOR.

LOOK OUT FOR THE MAN who is advertising an infallible cure for a corn, price $1, and money refunded if the corn does not disappear. If you send him a dollar you will receive by return mail the following recipe: "Cut off your toe."

THIS IS TRULY AN AGE OF ICONOCLASM. A cold-blooded scientist now comes forward to say that the old oaken bucket, celebrated in song and story, is simply an iron-bound death dealer, a condensed mass of nitrogenous and phosphatic filthiness, and the home of the microbe and bacterium.

"I HAVE A GOOD MIND to lay off and rest a couple of weeks," said a young journalist, wearily, as he finished a thrilling ten-line notice of Brown's bakery and leaned back in his chair. "You have that," warmly exclaimed the grizzly old newspaper man, who was wrestling with two columns of telegraph and a stack of proof. "You have the best mind to rest with that I ever saw."—*Exchange.*

MAGISTRATE (to prisoner)—"You say, Uncle 'Rastus, that you took the ham because you are out of work and your family are starving. And yet I understand that you have four dogs about the house." Uncle 'Rastus—"Yes, sah, but I wuddent ask my family to eat dogs, yo' honah!"

THE OTHER DAY AN EXQUISITE told the daughter of a prominent official—an unusually clever young woman—that he always slept in gloves because it made his hands so soft.

"Do you sleep in your hat, too?" artlessly inquired the damsel.

There was no reply; and I half suspect that the young man thought at the moment that his fair questioner was out of her mind. —*Boston Journal of Health.*

MARRIAGE.

SEYBERT—WIESS.—June 20, 1888, Dr. Frank F. Seybert (Jeff. Med. Col., 1881) to Ida B., daughter of Mr. and Mrs. F. Ferd. Wiess, of Council Bluffs, Iowa.

OBITUARY.

DR. DAVID MERRITT.

Dr. David Merritt, who recently died at his residence in Philadelphia, was born at St. John, New Brunswick, in 1830. He came to this city when nineteen years of age, and began the study of medicine, and was graduated at the Pennsylvania Medical College in March, 1851. He practised his profession until the breaking out of the war, when he joined the 55th Regiment, Pennsylvania Volunteers, under Colonel Richard White. After serving three years as surgeon with that body, he connected himself with the Hancock Veteran Corps, serving in the same capacity until the close of the war. He resumed his practice in this city, and three years ago he had an attack of empyema, which eventually caused his death. He leaves a widow, a son and a daughter.

CARL L. JENSEN, M.D.

Carl L. Jensen, a well-known manufacturing chemist, who resided at No. 2039 Green street, Philadelphia, died of typhoid fever in New York City, June 9, after a short illness. He was in his 43d year, and was born in Denmark, graduating as a chemist at Copenhagen. He came to this country in 1869, and for the last eight years lived in Philadelphia, where he devoted himself to the manufacture of preparations of pepsin. He leaves a widow and three children.

JOHN WIEGAND SNOWDEN, M.D.

Dr. John Wiegand Snowden was born in Philadelphia, April 22, 1823. He was the son of Thomas and Sarah M. Snowden. His father was for over thirty years associated in business with John Wiegand, as manufacturers and importers of surgical instruments in Philadelphia. Thomas Snowden took an active part in public affairs in Philadelphia prior to 1854, and represented the old South Mulberry ward for many years in its Common and Select Councils, serving for ten years as President of the former.

Dr. Snowden was educated at the Engle Classical School in Philadelphia. He assisted Dr. George McClellan as demonstrator of anatomy, and was graduated from the Medical Department of the University of Pennsylvania in 1844. He began the practice of medicine in his native city, but soon removed to Middletown, Delaware, and thence to Chew's Landing, Camden county, New Jersey. He was of feeble constitution, and subject to pulmonary diseases. Learning from the natives that a residence in the barrens of New Jersey, called the Pines, was a sovereign remedy for these affections, he removed in 1846 into what was then the centre of that wilderness, near where is now the Ancora Station, on the Camden and Atlantic Railroad. In June, 1849, he joined the Camden County Medical Society, and was at his death the oldest member on its roll. He had filled all the important offices in the Society, having been twice its President, and for nine years Chairman of its Standing Committee, resigning in 1887, in consequence of ill health. He was a member of the New Jersey State Medical Society, and its President in 1882. He was also a member of the American Medical Association, and of the Obstetrical Society of Philadelphia.

A few years before his death he removed from Ancora to Hammonton, six miles below the former place, and just within the limits of Atlantic county, where he died May 28, 1888.

At a special meeting of the Camden County Medical Society, held May 30, 1888, the following was ordered to be placed upon the minutes:

In the death of Dr. John W. Snowden, who was a member of this Society for thirty-nine years, who rarely was absent from its meetings, who filled its highest posts of honor, maintained its dignity, and used his rich fund of experience and ripe judgment in the interest of harmony, this Society has sustained a great loss.

We commend to the members of the Society this bright example of the *true physician*, one who for forty years, by night and by day, in sunshine and in storm, devoted talents worthy of a more brilliant theatre, to the people of a sparsely settled district, and ministered with great medical skill to alleviate their sickness and sufferings, and often with true Christian piety furnished them with spiritual consolation.

We extend to his bereaved family our sincere sympathy in their sorrow and loss, knowing that, although his place cannot be filled, their and our remembrance of him will be of one who in all his relations in life, both public and private, was the embodiment of purity, honor and dignity.

H. Genet Taylor, M.D.,
E. P. Townsend, M.D.,
E. L. B. Godfrey, M.D.,
Daniel Strock, M.D.
J. F. Walsh, M.D.,
Committee.

RACHEL L. BODLEY, M.D.

Dr. Rachel L. Bodley, Dean of the Women's Medical College of Pennsylvania, died at Philadelphia, June 15. She had been suffering with heart trouble, but was not taken seriously ill until June 12, when she began to fail rapidly.

Dr. Bodley was born in Cincinnati, O., December 7, 1831. In 1844 she entered the Wesleyan Female College, in that city, and was graduated after a course of five years. She was then appointed a teacher and remained until 1860, advancing to the position of preceptress in the higher collegiate studies. She came to Philadelphia in the autumn of that year, and became a special student in advanced chemistry and physics in the Polytechnic College. She returned to Cincinnati in February, 1862, and was appointed Professor of Natural Sciences in the Cincinnati Female Seminary, which position she held three years. In 1865 she was called to the chair of chemistry and toxicology in the Women's Medical College of Pennsylvania. She accepted and thus became the first woman professor of chemistry. She was elected Dean of the Faculty in January, 1874, and from that time until her death she devoted herself exclusively to the college, promoting its interests and striving to elevate her sex, and to secure for woman and her work respect and recognition.

In 1879 the honorary degree of M.D. was conferred upon her by the Women's Medical College of Pennsylvania.

In 1880 she was made a member of the Franklin Institute, and was the first woman to deliver any extended course of lectures in the Institute.

Not the least of her services to the city was her service as School Director of the Twenty-ninth Section School Board, which position she held at the time of her death.

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Communications.

THERAPEUTICS OF DIPHTHERIA.[1]

BY A. JACOBI, M.D.,
CLINICAL PROFESSOR OF DISEASES OF CHILDREN IN THE COLLEGE OF PHYSICIANS AND SURGEONS, NEW YORK, ETC.

[Continued from page 802.]

The liquids which are to be injected must be warm and fairly mild. Solutions of chloride of sodium, two-thirds of one per cent.; saturated solutions of boric acid; one part of bichloride of mercury, 35 of chloride of sodium and 5000 of water, more or less; or lime water, or solutions of papayotin, will be found satisfactory. From the selection of these remedies it is at once apparent that the object in view is partly that of washing out and partly of disinfecting. I have not mentioned carbolic acid, which may be used in solutions of one per cent. or less. Its employment requires care, for much of the injected fluid is swallowed, and proves a danger to children of any age, but mostly to the young.

Most of the syringes I find in my rounds are abominations. The nozzle must be large, blunt and soft. After having recommended for many years the common hard rubber ear syringe, the sharp end of which was cut off, I now use always a short stout glass syringe, with soft rubber mounting in front.

When the children cannot, or must not be raised, I employ the same solutions from a spoon, or a plain Davidson atomizer. These applications can thus be made while the children are lying down, every hour, or very much oftener, without any or much annoyance. The nozzle must be large, so as to fit the nostril. A single spray on each side will generally suffice. I am in the habit of covering the common nozzle with a short piece of india-rubber tubing. For a day or two these injections of fluids or sprays must be made hourly. It is not cruel to wake the children out of their septic drowsiness—it is certain death not to do it.

Injections of the nose are oftener ordered than judiciously made. Hundreds of times have I been assured that they had been made regularly, hourly, for days in succession. Still there was a steady increase of glandular swelling and sepsis. I never believe a nurse to have made them regularly unless I have seen her doing it. They *will* turn up their syringe vertically, and not horizontally; the fluid *will* return through the same nostril. On the successful injecting or spraying of the nares hangs every life in a case of nasal diphtheria. I have long learned to look upon a neglect to tell at every visit how to make an injection, as a dereliction of duty. This may appear a trifling way, but it is a safe one. The nurse must be made to tell you that at every injection the fluid returns through the other nostril, or through the mouth, or is swallowed.

The procedure is simple enough, and need not take more than half a minute for both nostrils. A towel is thrown over the child's chest up to the chin and the child gently raised in bed by the person who is to make the injection. This person sitting on the bed steadies the patient's head against her chest while somebody else holds the patient's hands. The syringe is introduced horizontally, by the person sitting behind the patient and gently emptied. No time must be lost in refilling and attending to the other side. When pain is complained of in the ears more gentleness is required, or the spray, or pouring from a spoon, or minim dropper even, has to take the place of the injection. Many sins are committed in even doing

[1] A paper read at the meeting of the Philadelphia County Medical Society, May 23, 1888.

this simple thing. The unfortunate little one is made to see all the preparations and is worried and excited, and the necessary gentleness in the proceedings is neglected. The cases reported by me in a discussion on the local treatment of diphtheria before the Section on Theory and Practice in the New York Academy of Medicine, read as follows: [1]

"There were two trained nurses, and two children of six and four years. When I saw the little four-year-old the other was dead. Where did he die? His head between the knees of the trained nurse. They had been told Dr. Jacobi ordered nasal injections to be made every hour in such cases. Every hour the unfortunate boy was lugged out of bed, protesting and fighting, and wearing out his little strength in his battle against two trained brutes; had his head rammed between the knees of one of them who was herself comfortably seated on a chair while the other did the rest; and thus the boy was murdered. When I heard that fearful story from the smiling lips of that person, I begged and pleaded, and showed her how to do it gently. A week afterward the doctor told me that the little girl died between the knees of one of the smiling creatures, and neither of them is in the State prison."

What is the concentration in which antiseptic injections should be used? For twenty-five years and more, while employing irrigations and injections frequently, I had used quite weak solutions and felt assure of their efficacy. All at once (when the gospel of the bacteria was being preached) it was claimed that weak solutions were useless and a snare, because antiseptics, and particularly carbolic acid, would not destroy bacteria and bacteria-poisons except in such doses and concentrations as would necessarily destroy blood and tissues first. I felt dismayed, but still continued in my heretic ways, hoping that improved knowledge would finally harmonize theory and practice. So it happened. In the *American Journal of the Medical Sciences* for January, 1881, T. Mitchell Prudden proved that a solution of one-sixteenth of one per cent. of carbolic acid prevents the emigration of white-blood corpuscles under circumstances otherwise favorable to inflammation; and Koch found that though bacteria are not easily killed, their growth is stopped by a solution of one part of carbolic acid in 850, and their activity by one in 1200. These effects are all that is required for practical purposes; thus the frequency of applications is justified by both necessity and safety.

[1] *N. Y. Medical Record*, 1887, p. 403.

Diphtheritic adenitis, the swelling of the cervical glands near the angles of the lower jaw, to which I have alluded as an ominous symptom, points to nasal and nasopharyngeal infection. The treatment consists in disinfection of the absorbing surfaces.

Direct local treatment of the glands, if not entirely useless, is, at all events, of minor importance and efficiency. Applications of one part of carbolic acid to ten of alcohol, irritate both surface and patient more than they can do good. Inunctions may do some good by friction (massage); inunctions with some absorbable material in them may do a little better. The common iodide of potassium ointment is useless; iodide of potassium in three or five parts of glycerine is more readibly absorbed; the same in equal parts of water, with a little animal fat, and six or eight times its quantity of lanolin, gives an ointment which is readily absorbed. Iodine is found in the urine within a few hours. Iodoform may be utilized in the same way. Injections of iodoform in ether, which I suggested some time ago, are too painful. Mercurial inunctions, those of blue ointment, require too much time for any effect to take place. Oleates are too irritating locally; a lanolin ointment would prove more satisfactory. After all, however, the readiest method of reducing the swelling of the glands, and improving the prognosis accordingly, is that of cleansing and disinfecting the field of absorption. The rare cases of suppuration in these glands require incision and disinfection. They are as ominous as rare, however. There is but little pus, as a rule, but one or many local deposits of disintegrated gland cells and gangrenous connective tissue. The incisions must be extensive, the scoop and concentrated carbolic acid must be freely used. In these cases hemorrhages may occur, some of them very difficult to manage. I have seen some of them terminate fatally. In these carbolic acid must be avoided. Compression, actual cautery, and acupressure, have rendered good service. Solutions of iron must be avoided, for the scurf formed is a shield behind which deleterious absorption is going on constantly in such wounds, as it does in the uterus.

Besides sepsis, the great dangers in diphtheria are heart failure and strangulation. The latter has its own indication, to which I shall not allude to-day. Heart failure exhibits itself sometimes quite suddenly, but, as a rule, it is foreshadowed by a gradually increasing frequency, weakness of heart-beats and pulse, and the equal length of the intervals between the feeble systole and diastole,

and diastole and systole. This equality is always a dangerous symptom. Heart failure is due, besides the influences common to every disease and every fever, to myocardial changes. These may depend on the influence of septic decomposition of the blood, and the ill-nutrition of the heart-muscle depending thereon, or on the direct diphtheritic changes of the tissue, or both. These changes and dangers set in, sometimes, at a very early period. Thus whatever enfeebles must be avoided. Patients must be spared every unnecessary activity. They must remain in bed, without excitement of any kind, take their meals, and evacuate their bowels in a recumbent or semi-recumbent position; crying and worrying must be avoided; the room kept airy, and rather dark, so as to encourage sleep if the patient be restless. In no disease, except, perhaps, in pneumonia, have I seen more fatal results from sudden changes of posture, or from exertion. Unless absolute rest be enforced, neither physician or nurse has done his or her duty.

The threatened feebleness of the heart yields a positive therapeutical indication. In no disease is the danger greater on the side of the heart, in no disease is the indication for sustaining and strengthening the heart more positive from the very beginning. Digitalis, strophanthus, sparteine, besides camphor, alcohol and musk, must not be postponed until feebleness and collapse have set in. It is possible, or probable that they will appear; and it is certain that a cardiac stimulant will do no harm. It is safe, and advisable to use them at an early date. This is especially necessary when antipyrine or antifebrine is given. A few grains of digitalis, in a palatable and digestible form, may, or must, be given daily. When a speedy effect is required, one or two doses of from two to four grains are not too large, and must be followed by smaller ones. When it is justly feared that the effect of digitalis may be too slow, I give, with or without the former, sulphate of sparteine. An infant a year old will take one-tenth of a grain four times a day, as a matter of precaution, and every hour or every two hours in an emergency.

Of at least the same importance as cardiac tonics are alcoholic stimulants. The advice to wait for positive symptoms of heart failure and collapse before the life-saving apparatus is employed, is bad. There are cases which get well without treatment, but we do not know beforehand which they will be. No alleged mild case is safe until it has recovered. When heart failure sets in—and often it will occur in apparently mild cases—our efforts are too often in vain. Thus alcoholic stimulants ought to be given early, and in large quantities, though amply diluted. There is no such thing as intoxication or danger from it, in septic diseases. A few ounces daily may suffice, but I have seen ten ounces daily of brandy or whiskey save children who had done badly with three and four.

Coffee is a good stimulant for the heart. Camphor may be employed to great advantage for the same purpose. From five to twenty-five grains may be given daily, as camphor water, or in a mucilaginous emulsion, which is easily taken. It does not upset the stomach as ammonium carbonate is liable to do. It may be employed subcutaneously when a rapid effect is aimed at, in five parts of oil, which is milder and more convenient than ether.

But the best internal stimulant, in urgent cases, is Siberian musk, in powders, or with mucilage. When required at all it ought to be given in sufficient doses, and at short intervals. When ten or fifteen grains administered to a child one or two years old, will not accomplish, within three or four hours, a return of a more satisfactory heart's action, the prognosis is very bad.

Besides exhaustion at the height of the disease, we have paralysis during convalescence, or intense anæmia long after apparent recovery. This anæmia may be general, or is local, and then mostly cerebral.

Diphtheritic paralysis, though of different anatomical and histological origin, yields in all cases a certain number of identical therapeutical indications. These are: The sustaining of the strength of the heart by digitalis and other cardiac tonics. A child of three years may take daily, for a month, three grains or its equivalent; for instance, one grain of the extract. This is an indication on which I cannot dwell too much. Many of the acute, and most of the chronic diseases of all ages, do very much better by adding to other medications a regular dose of a cardiac tonic. It is true that it is a good practice to follow the golden rule to prescribe simply, and, if possible, a single remedy only, but a better one is to prescribe efficiently. A prescription paper with a single line on it looks well, but a readily convalescent or well man, looks better.

Besides, there are some more indications: Mild preparations of iron, provided the digestive organs are not interfered with. Strychnia or other preparations of nux vomica at all events. In ordinary cases a child of three years will take an eightieth of a grain three or four times a day. Local friction, massage of the throat, of the extremities, and trunk, dry or

with hot water, or oil, or water and alcohol; and the use of both the interrupted and continuous currents, according to the known rules, and the locality of the suffering parts, find their ready indications. The paralysis of the respiratory muscles is quite dangerous; the apnœa resulting from it may prove fatal in a short time. In such cases the electrical current used for very short periods, but very frequently, and hypodermic injections of sulphate of strychnia in more than text-book doses, and frequently repeated, will render good service. I remember a case in which these, and the occasional use of an interrupted current, and occasional artificial respiration by Silvester's method, persevered in for the better part of three days, proved effective.

Chloride of Iron.—I am still, as I was in my first paper on diphtheria, in 1860, an advocate of the internal use of chloride of iron. Its mode of administration I have not changed much these twenty years. In a public lecture delivered before a New York audience, by an European authority, whose name has lately appeared a little more prominently in the newspapers than an American physician would wish, I was highly praised for giving a few drops of the tincture of the chloride of iron a few times a day. This eulogy I have always tried not to deserve, for the efficient method of its administration is not that. The chloride of iron is an astringent and antiseptic. Its contact with the diseased surface is as important as is its general effect; therefore it must be given frequently, in hourly or half hourly doses, even every twenty or fifteen minutes. An infant of a year may take three or four grammes a day, a child of three or five years, eight or twelve. It must be mixed with water to such an extent, that the dose is half a teaspoonful or a teaspoonful; a drachm in four ounces allows half a teaspoonful every twenty minutes. No water must be drunk after the medicine. As a rule, it is well tolerated. There are some, however, who will not bear it well. Vomiting or diarrhœa is a contra-indication to persevering in its use, for nothing must be allowed to occur which reduces strength and vigor. A good adjuvant is glycerine, better than syrups. From ten to fifteen per cent. of the mixture may consist of it. Now and then, but rarely, it is not well tolerated either. When diarrhœa sets in glycerine must be discontinued. Still these cases are rare; indeed, the stomach bears glycerine very much better than the rectum. In the latter, the presence of a small dose of glycerine is known sometimes to produce large evacuations, a result appropriated and utilized by an advertising nostrum monger.

In connection with this remedy, I wish to make a remark of decidedly practical importance. I know quite well that recovery does not always prove the efficacy of the remedy or remedies administered. But I have seen so many bad cases recover with chloride of iron, when treated after the method detailed above, that I cannot rescind former expressions of my belief in its value. Still, I have often been so situated that I had to give it up in peculiar cases. These are cases in which the main symptoms are those of intense sepsis, I should say cases in which the iron and other rational treatment was not powerful enough to prevent the rapid progress of the disease. Children with naso-pharyngeal diphtheria, large glandular swelling, feeble heart and frequent pulse, thorough sepsis, and irritable stomach besides, those in which only large doses of stimulants, general and cardiac, can possibly promise any relief, are better off without the iron. When the circumstances are such as to leave the choice between iron and alcohol, it is best to omit the iron and rely on stimulants mostly. The quantities required are so great that the absorbent powers of the stomach are no longer sufficient for both.

Nor is iron sufficient or safe in those cases which are preëminently laryngeal. To rely on iron in membranous croup means waste and danger.

Mercury.—The first volume of *A system of Practical Medicine by American Authors*, which appeared in 1885, contains in an article on diphtheria, written in 1884, the following remarks on page 705:

"Not all cases of diphtheria are septic or gangrenous, nor are all the cases occurring during an epidemic of the same type. Some have the well-pronounced character of a local disease, either on the tonsils or in the larynx. The cases of sporadic croup, met with in the intervals between epidemics, present few constitutional symptoms, and assume more the nature of an active inflammatory disease, very much like the sporadic cases of fibrinous tracheo-bronchitis. These are the cases in which mercury deserves to have friends, apologists, and even eulogists. Calomel, 0.5–0.75 gramme (grs. viii–xii), divided into thirty or forty doses, one of which is taken every half hour, is apt to produce a constitutional effect very soon. Such, with minute doses of one milligramme (gr. $\frac{1}{60}$), or more, of tartar emetic, or ten or twenty times that amount of oxysulphuret

of antimony, have served me well in acute fibrinous tracheo-bronchitis. But the mucous membrane of the trachea and bronchi is more liable to submit to such liquefying and macerating treatment than the vocal cords. The latter have no muciparous glands like the former, in which they are very copious. And while the tracheal pseudo-membrane, though recent, is apt to be expelled through a tracheal incision at once, that of the vocal cords takes from six days to sixteen or more for complete removal. Still, a certain effect may even here be accomplished, for maceration does not depend only on the local secretion of the muciparous glands, but on the total secretion of the whole surface, which is in constant contact with the whole respiratory tract. Thus, either on theoretical principles, or on the ground of actual experience, men of learning and judgment have used mercury in such cases as I detailed above, with a certain confidence.

"If ever mercury is expected to do any good in cases of suffocation by membrane, it must be made to act promptly. This is what the blue ointment does not. In its place I recommend the oleate, ten or twelve minims of which may be rubbed into the skin along the inside of the forearms or thighs, or anywhere else when those surfaces become irritated, every hour or two hours. Or repeated doses will be useful such as mentioned before, or hypodermic injections of corrosive sublimate, in one-half or one per cent. solution in distilled water, four or five drops from four to six times a day or more, either by itself, or in combination with the extensive use of the oleate, or with calomel internally. Lately, the cyanide of mercury has been recommended very strongly. I hardly believe that it will work more satisfactorily than any other equally soluble preparation. Within the past few years the internal administration of bichloride of mercury has been resorted to more frequently and with greater success than ever before.

"My own recent experience with it has been encouraging, and so has that of some of my friends. Wm. Pepper gave one-thirty-second of a grain of corrosive sublimate every two hours in a bad form of diphtheritic croup, with a favorable result. But in this very bad case, desperate though it was—a child of five years, respiration 70, pulse 160—large membrane 'evidently from the larynx' had been expelled before the treatment was commenced on the seventh day of the disease. The solution ought to be given in solution of 1 : 5000, and in good doses. A baby, a year old, may take one-half grain every day many days in succession, with very little, if any, intestinal disorder, and with no stomatitis. A solution of the corrosive sublimate in water is frequently employed of late as a disinfectant. It acts as such in a dilution of 1 in 20,000. As healthy mucous membranes bear quite well a proportion of 1 : 2000 or 3000, any strength between these extremes may be utilized. A grain of the sublimate in a pint or more of water, with a drachm of table salt, will be found both mild and efficient. As a gargle and nasal injection it will be found equally good. But it has appeared to me that frequent applications give rise to a copious mucous discharge; hourly injections into a diphtheritic vagina become quite obnoxious by such over-secretion, which ceases at once when the injections are discontinued. Thus, when it is desirable not only to disinfect, but also to heal the diseased surface, the injections with corrosive sublimate appear to yield a result inferior to less irritating applications."

These remarks of 1884 constitute what I consider a great progress over the statements of my treatise on diphtheria, 1880, which are more cautious and negative. Extensive experience with the remedy increased my favorable opinion of its efficiency to such an extent as to induce me to publish a number of cases and conclusions in the *Medical Record* of May 24, 1884.

They have been amply justified by the observations of the last four years, so that I am fully prepared to commit myself to the following statements: My conviction of the utter uselessness of internal medication in laryngeal diphtheria, membranous croup, is strongly shaken. The mortality of 90 or 95 per cent. of the cases not operated upon has no longer existed these five or six years, in my observation. The above figures were by no means taken from small numbers. For since 1860 I have performed tracheotomy more than 500, perhaps 600, times, have assisted in as many more operations, and seen at least a thousand cases of membranous croup which were not operated upon at all. During the last six years I have seen no less than 200 cases, perhaps many more. Amongst them, recoveries have not been rare. In the practice of no less a man than O'Dwyer, I have seen two cases of general and laryngeal diphtheria in the same family which got well without any operative procedure. Such recoveries have taken place in all ages, from four months upward. The uniform internal medication consisted in the administration of the bichloride of mercury. The smallest

daily dose was a quarter of a grain (15 milligrammes). Half a grain daily continued through five or six, sometimes eight, ten, or even twelve days, has not been rare amongst children of from three to six years. The doses varied from one-sixtieth to one-fortieth of a grain, and sometimes more. They are given every hour. They require dilution in a tablespoonful of water, or other compatible fluid, for instance milk, in order to be quite innocuous. They are not liable to produce gastric or intestinal irritation. When the latter occurred, it was generally found that by some mistake the solution was as strong as 1-2000 or 1-3000. In the few cases in which it did exist, or was believed to result from the remedy, a few minims of camphorated tincture of opium administered with every dose, for a short period, proved sufficient to check it. The beneficial effect of the remedy depends greatly upon the time of its administration. As a rule, such complete stenosis as necessitates surgical interference, develops only after days. This necessity is often obviated by the remedy when given as detailed. When the operation is required after all, the treatment must be continued. I have never since 1863 seen so many cases of tracheotomy getting well as between 1882 and 1886, when the bichloride was constantly used as mentioned. Nor am I alone with these observations. I can name a dozen New York physicians, some of whom have often performed tracheotomy, who can confirm the above statements from their own observations. Nor does the opinion of those differ who constantly perform intubation. I know that O'Dwyer, Dillon Brown, and Huber have come to the same conclusions, the latter having been a successful tracheotomist before he earned his laurels with intubation.

My experience in regard to the efficacy of the bichloride of mercury is mainly gathered in cases of laryngeal diphtheria, and a limited number of fibrinous bronchitis. It is there where it has been especially effective. Still I must not say that they were localized affections. These, with us, are but very scarce. Our cases of diphtheritic laryngitis are mostly decreasing, and complicated with either diphtheritic pharyngitis, or rhinitis, or both. Not a few, mainly of the latter kind, exhibit constitutional symptoms, sepsis. But cases of that kind also I have seen getting well. One of the most interesting was that of a little girl of seven years whom I saw a single time in consultation with Dr. J. Anderson. There was nasal and pharyngeal diphtheria, cervical adenitis, and some laryngeal stenosis. I recommended an hourly dose of one-fortieth of a grain of bichloride, which she took for ten days, also nasal injections of the same, one grain to a pint. They were made hourly for many days, and altogether continued for more than a fortnight, for the patient lived so long, and is still alive. She swallowed almost all the nasal injections, and great was my surprise when after some weeks I received the report of the case and learned that about twenty grains of the bichloride had found their way into the stomach of the little girl. She lived, had but little stomatitis, and hardly any intestinal irritation. If the case does not prove anything else, it proves this, that even desperate cases will get well; this case got well with the bichloride of mercury, and resembles all the other cases in this, that after the rational and careful administration of solutions of bichloride of mercury, local mercurial symptoms about gums, mouth, pharynx, and intestines, are extraordinarily rare in infancy and childhood.

ABDOMINAL DISEASE AND INSANITY.

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One of the chief problems with which the asylum physician has to deal is the regulation of the functions carried on by the abdominal viscera. The introduction and digestion of a sufficient amount of nutritious food, its proper assimilation and the eventual disposition of the *alvine residua*, are among the most constant objects of his care. It is not surprising that, recognizing the intimate relationship between abnormal mental states and gastric, hepatic and intestinal disturbances, the ancients should have fallen into the error of regarding the latter as a frequent primary cause. Down to the day of Schroeder Van der Kolk, eminent alienists sought in various indefinitely known nervous connections, existing between the viscera and the brain, the channels by which what they called "sympathetic insanity" was mediated. A reaction occurred; Griesinger rejected the older view, inflicting the sarcastic term "copro-psychiatry" on it. More modern authors have gone even further, and state that the cases of alleged insanity due to visceral disease will not bear critical examination. In a now historical discussion, which took place in the Medico-Psychological Society of Paris, the majority of the debaters took the position, that inasmuch as the most important

feature of the cases of alleged sympathetic insanity was a pre-existing disposition to nervous and mental disease, without which the visceral cause would probably have remained inoperative, it was not advisable to retain the term "sympathetic insanity" in our nomenclature.[1]

I am myself of the opinion that nothing is gained, and much lost, by designating a form of insanity by its cause. When an alienist shows me a patient and declares him to be a case of "gastric" or "rectal insanity," he has given me no valuable information regarding the clinical manifestations of the case. It were as just for a clinician to designate a case of bronchiectasis, with its accompaniments, as "stone-cutter's disease." But it is legitimate and useful for the alienist, after defining the clinical form he is dealing with, designating it, say, as a "hypochondriacal paranoia," or a "persecutional melancholia;" to add, "on a foundation of dyspepsia," or "intimately related to a rectal prolapsus."

Diseases of the gastro-intestinal tract, and the appended glands, bear a far more important part in the causation and modification of insanity than is usually admitted in text-books on the subject. The reaction against the view held by the ancients, though in the main practical and just, has overstepped the bounds of truth. When we find a man who is suffering from gastro-intestinal catarrh, manifest an irresistible tendency to malice and chicanery during the process of digestion, from which he is radically relieved by each alvine evacuation, we are led to suspect that the connection between the visceral disorder and the mental state is more than that of a mere coincidence. And when we discover in another patient who, already depressed by veritable causes of grief, contracts a gastric catarrh; and every time the burning feeling rises in her throat—and at no other time—indulges in the delusion that she is being burnt, we become inclined to admit that visceral disorders may excite a marked modifying influence on an existing mental disorder.

Lord Byron[2] stated it as his belief that body and mind are in indissoluble wedlock, for after a fit of indigestion he experienced a complete inertia of all his mental faculties. It is a notorious fact that dyspeptics are as pessimistic as sufferers from pulmonary trouble are optimistic. The dyspeptic indulges in a selfish interpretation, and according to his previous temperaments, he will, if this were choleric or sanguine, become quarrelsome, irritable and snappish; if it were lethargic, he will be inclined to somnolence; if it were melancholic, he will become melancholy or hypochondriacal. A marked disinclination to exertion is often noted particularly after meals, and in not a few cases, especially if gastric dilatation[3] be a complication, hallucinations and illusions are noted to occur either only after certain injuries or irritating ingesta, or at the acme of the digestive process.[4] The influence of stomach disturbance on the mind is too often underrated by practitioners of medicine. Not a year ago, a prominent medical practitioner of St. Louis committed suicide in consequence of spasmodic seizures due to hour-glass contraction of the stomach.[5] Probably no other single organ is responsible for so much subjective misery. There are patients in the practice of every physician who are as bright and cheerful on peptonized milk, as they are unhappy, wretched, and tired of life on fried potatoes and pork cutlets. Such patients soon become morbidly self-observant; the occurrence of a flatus, or an eructation, is anxiously noted; an easy evacuation is triumphantly extolled; a coated tongue plunges them in the deepest dejection. Add to this that the general nutrition may be suffering in consequence of the gastric disorder at this time, and the effect of this continual brooding may be anticipated. Many a testy hypochondriac has no other discoverable cause for his mental disorder than a protracted gastric catarrh. And his mental state is a veritable barometer of the better or worse condition of his stomach.

The extreme re-action against the views of the ancient writers occurred before the time when the grave, nervous consequences of abdominal disease were understood. Certainly, if Griesinger and his followers had borne in mind that apoplectiform vertigo may occur from a comparatively slight gastric disturbance, that speech difficulties may appear in dyspeptics, and at no other time than after meals, they would not have so arbitrarily designated that phase of alienism, when the visceral state was carefully studied, as "copro-psychiatry." As a rule the *ego* of the dyspeptic is not materially affected, the mental faculties are not impaired in form. But in a large proportion of cases there is an inability to exert the will powers, even to carry out so simple an act as the picking up

[1] Annales Medico-Psychologiques, 1857, pp. 105, 114, 273, 424, 436, 450.

[2] *Journal*, 1821.

[3] H. Duchon-Doris; De quelques troubles cérébraux liés à la dilatation de l'estomac. Thèse de Paris, 1887.

[4] Hardy, *Gazette des Hôpitaux*, 1885, No. 107.

[5] *N. Y. medizinische Presse*, 1888, No. 1, p. 37.

of an object that has fallen from the listless grasp. In a few cases of this kind the memory and speech are inhibited after meals. In others cutaneous hyperæsthesia develops, peculiar reflex symptoms, numbness of the hands (especially of the left), precordial oppression, and pain to the left of the fourth to seventh dorsal vertebræ are added, and the already melancholy patient develops all sorts of hypochondriacal fancies.

Recent observations tend to show that the liver, erroneously regarded as related to melancholia by the ancients, does exceptionally occupy an etiological relation to mental disorder. The philosopher de la Mettrie, [1] protégé of Frederick the Great, referred to such a case, in which the only lesion found after death [2] was an hepatic abscess. Hammond repeatedly aspirated the liver, and in some cases with remedial results—obscure abscesses, whose existence had not been determinable by any of the usual signs, having been the sole cause of a depressed mental state. He claims that vertigo, insomnia, transitory confusion of ideas, inability to concentrate thought without aggravating the symptoms mentioned, and great depression are the characteristic symptoms. Cyr has reported [3] a number of cases where attacks of hepatic colic were followed by a stupor which almost approached a coma in degree. He attributes this state on account of its intimate alliance with the attacks of colic and brief duration, rather to the effect of the painful state on the nervous system than to any toxic influence excited by the biliary ingredients in the circulation. That acute yellow atrophy of the liver is often accompanied by furious delirium, in which the patients strike and bite at the bystanders—a delirium of high intensity and remarkably brief duration—is a recognized fact of hepatic pathology. [4]

Diseases of the peritoneum are as exceptionally enumerated among the causes of mental disease. Thus, Bergmann [5] found a scirrhous degeneration of the epiploon in a case of stupor. A most remarkable case is published by Barrey. [6] The patient experienced repeated attacks of melancholic frenzy, and in the interval exhibited a passive melancholia marked by an intense expression of agony. Progressive wasting ensued, and the patient manifested a marked repugnance to covering of any kind, and threw off his clothing and the bed-covers, so that for months before his death he lay naked. Aside from vague complaints about his food, and desire to see his family, his only spontaneous utterances were demands for prolonged baths and that his abdomen be opened to remove some injurious substance there. The patient's feelings were clinically truer than the diagnosis of his physicians. He had the habit of bending forward and clasping his hands over the epigastrium, but repeated careful examination failed to show any special morbid condition. He died after a seven months' sojourn in the asylum. The peritoneum was found to be thickened and degenerated, agglutinating the various folds of the intestines, thus forming a common mass, everywhere permeated by a blackish-green liquid. Two large pouches filled with this fluid were found; the intestines showed advanced putrefactive change, but evidently the morbid process had antedated the asylum sojourn.

The rectum plays a very modest part in the etiology of insanity. The older writers assigned to hemorrhoidal diseases a very prominent rôle in the natural history of hypochondriacal and paralytic mental disorder. The presence of hemorrhoids in the insane is to-day regarded either as an accidental coincidence, or at most as a collateral feature of the "arthritic and herpetic diathesis" as Charpentier [7] recently designated it. In a few cases there seems to have been a direct relation between the mental state of melancholic patients and their rectal disease. One of my patients had for fifteen years suffered from so profound a degree of atony of the rectum, that she had frequently to resort to the disgusting procedure of removing the fæces *propriâ manû* when they were hard; when they were soft she suffered from active incontinence. During this time she has at various periods had fears of having Bright's disease, phthisis, etc. Finally, great depression developed, she became very irritable, and often whilst the noise of children playing annoyed her, an "inner feeling" urged her to commit suicide. On examination a marked prolapse of a rectal fold was found, and it was recorded that every exacerbation of her mental symptoms was preceded by an aggravation of the irritation connected with this prolapsus. She had considerable tym-

[1] Ouvrage de Penelope II, cited by Pick; *Jahrbücher für Psychiatrie* I. p. 56.

[2] Neurological Contributions, Vol i, No. 3, 1881.

[3] Union Médicale, 1882, No. 63.

[4] Legg. The Bile, Jaundice and Bilious Diseases, 1880.

[5] Allgemeine Zeitschrift für Psychiatrie. 1845, Vol. II.

[6] Annales Medico-Psychologiques, p. 506. 1868. Series 4. Vol. 7.

[7] Proceedings of the Paris Medico-Psychological Society, Nov. 29, 1886; reported in *Annales Médico-Psychologiques*, April, 1887. P. 283.

panites, was greatly annoyed by borborygmi, and experienced a burning feeling from head to foot, latterly accompanied by sharp pains in the limbs on such occasions. In a case of melancholia complicated by a rectocele, reported by Nolé[1], suicide was perpetrated. Each exacerbation of anxious melancholia was preceded by lumbo-sacral pain, which gradually rising in severity, at length caused the patient to cry out in despair and to beat her eyes with her hands. This condition of frenzy passed into one of morose taciturnity, in which she stared fixedly at the ceiling.

I have seen a number of cases, in which cardiac palpitations, spells of anxious terror and impulsions to suicide, followed by reactionary self-reproach and intermingled with morbid fears, were due to a conjoined dyspepsia and rectal trouble. In one such case there was abnormal narrowness of the rectum, and a radical cure followed the dilatation of both sphincters. In another, where the ingestion of hard meat infallibly provoked the attacks of terror, it was observed that very severe seizures were followed by a diarrhœa which the patient had come to regard as critical.[2] Kish[3] reports similar cases in which he determined arhythmy of the pulse during the spells of terror, and which he claims were relieved by the waters of Marienbad.

There is a peculiar condition observed chiefly in young girls about the period of puberty, which, whatever its original course, is intensified and modified by the state of the stomach. This state does not appear to be continuously pathological, for in cases in which death from starvation had ensued, that organ was found to be apparently normal. It seems to be rather a functional perversion. A patient of this class develops a slight dyspepsia and, rendered morbidly sensitive by the existing predisposition to nervous disease, usually present in their families, and doubly so by pubescence, she contracts a positive dislike for food. Improper food causes distress, the tonics, appetizing cordials and chalybeates with which a mistaken therapeusis drenches her, aggravate the trouble, and dislike is metamorphosed into a belief that food is injurious. All the patient's energies are devoted to the one end of resisting the introduction of food, and the morbid concentration on self ultimately leads to the development of a full-blown delusion that God has forbidden her to eat. Meanwhile the stomach, originally perhaps but very slightly diseased, ceases to present any signs of gastric catarrh; yet the patient does not resume eating, but goes on living for months and months on an occasional sip of water, tea or broth, and is visited by crowds of the marvel-loving majority as a so-called "fasting girl." The proper place for such a patient is the asylum, where the apparatus for forced feeding employed with readily assimilable food would soon overcome the starvation, and the delusion that led to it. The stomach-tube has performed even greater wonders, if we are to credit the claim of Schüle, that the recovery of a hypochondriacal paranoiac whose attacks of dyspepsia were relieved as soon as the œsophageal sound had passed a certain point where there was resistance, was due to artificial feeding.[4]

Much interest attaches to the influence of intestinal parasites on insanity. That these are competent to provoke a variety of nervous troubles, such as chorea, eclampsia and epilepsy, is well known; but that there are well established cases in which actual insanity ensued is ignored by the majority of recent writers. The rapid cure of the mental disorder following the expulsion of the parasites is the significant proof that the etiological assignment was correct. Acute, sudden explosions of mania, hyphochondriacal states, with or without eclampsia, are found in these cases. I have myself seen only the mildly hypochondriacal variety, and that with tapeworm. Rolland[5] relates the following convincing case of insanity: A man, aged thirty-eight, after becoming fatigued at his work, experienced an unusual malaise, confusion of ideas, writing and speaking at random, showing a profound change in physiognomy, his eyes being injected, and making aggressive attacks on his surroundings, of which he lost the remembrance. He vomited a large ascaris at the height of his disorder, and the relief was so rapid that an emetic was given him, and after the vomiting of two more he recovered entirely. As a rule, the mental disorders associated with worms, if of an acute type, are either complicated with convulsions, or, as in the case just related, they are of an epileptiform character. The intestinal parasites which have their habitat low down in

[1] *Journal des Connaissances Mèdico-Chirurgicales*, January, 1845.

[2] It is not impossible that in one of my cases a toxic influence had played a part in the etiology of the nervous and mental disturbance. The gastro-intestinal trouble dated from a fish-meal, which had been followed by vomiting, prostration and diarrhœa.

[3] *Berliner klinische Wochenschrift*, April 1, 1887. P. 261.

[4] Report of the ninth meeting "Wanderversammlung der Sud-West Deutscher Neurologen und Irrenaerzte. *Archiv für Psychiatrie*, XV, p. 828.

[5] *Journal de Médecine de Toulouse*, Mai, 1845.

the bowel, notably the oxyuris, bear a less direct relation to insanity, where either by general irritation or by crawling into the genital passages of children, they provoke masturbation, and the latter habit leads to the development of insanity from self-abuse.

The clinical characteristics of insanity due to chronic disease of the digestive tract is depression. This depression has rarely the emotional depth of typical melancholia. To express myself coarsely, I would say, the true melancholiac is horrified at life; the dyspeptic melancholiac is disgusted with it. The true melancholiac is so intensely unhappy that he cannot muster up courage enough to hope for relief; the dyspeptic melancholiac is but too ready to try every new remedy or doctor—alas, too seldom willing to follow rational and necessary dietetic directions. Another characteristic feature of the mental disturbance due to visceral disease, is its rapid change in such remarkable parallelism with the somatic state. The patient who feels comparatively cheerful up to eleven in the morning, becomes snappish, ugly and irritable as he awaits the hour of the noonday meal. While eating, his cheerful condition returns; but at a period varying from a few minutes to an hour after meals he again becomes wretched, confused, incapable of exertion, desperate, anxious, filled with morbid fears and evil forebodings. Imperative conceptions and *folie du doute*, are often found; but they are probably due to nervous prostration brought on by the coexisting insomnia. This condition reaches its height between two and three hours after meals, to entirely subside with the next visit to the closet. Where the peritoneum is affected, and in relation with insanity, the pinched, painful expression of the countenance has been remarked, while with intestinal parasites the dilatation of the pupils, peculiar pallor and aggravation of the symptoms coincidently with or after borborygmi, direct attention to the source of the trouble.

The various diseased conditions above referred to stand in a direct causal relation to insanity in but a small proportion of cases. More frequently their presence modifies special symptoms developed in those insane from other causes. Thus it has been noted that gastro-intestinal disease occurring in a depressed lunatic is very likely to determine the delusion of being poisoned, and thus lead to refusal of food and voluntary starvation. Hepatic disease aggravates, if it does not provoke depression. Cancerous disease in delusional lunatics sometimes determines the illusion that there is a wild beast in the stomach. The influence of intestinal stricture, of epiploic bands and peritoneal adhesions in modifying the superficial expression of insane beliefs is notorious. One such patient under the author's observation claimed that he had a "doctor in his belly." Esquirol relates the case of one who asserted he had a whole council of popes and all the personages of the New Testament in the same cavity. The study of such symptoms is, however, more interesting than profitable, for they do not expose any essential relation between cause and effect, but merely an accidental feature of disease. The lunatic who, because he feels flatus move from coil to coil of his gut, struggling to pass constricted or agglutinated segments of the same, believes that there is a living thing within him, suffers from a lack of observing and reasoning power, which, in the absence of the visceral disorder, would cause him to base an equally absurd delusion on the observation of some outside occurrence. The operation of visceral disease in the production of mental disease in persons of previously sound mental health and sound antecedents is extremely limited, if not nearly *nil.* But it plays an important rôle as an exciting cause in many of our neurasthenic and hereditarily predisposed patients. Proper attention to the somatic disturbance is often therefore attended by results which strike the patient as magical. The relief of a gastric catarrh causes the disappearance of anxious terrors; of a constipation, of morbid fears; the expulsion of worms, of a distressing convulsive or maniacal disorder.

712 Lexington Ave., May 26, 1888.

SMALL DOSES; THERAPEUTIC CONSIDERATIONS.

BY JOHN AULDE, M.D.,

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The short paper on "Small Doses," recently published in this journal, having met with a flattering reception, not only in this country but abroad, I have thought it advisable to continue the discussion by the presentation of some further therapeutic considerations. My object in so doing will be appreciated by a reference to the various views which have been advanced as to the *modus operandi* by which the therapeutic results of small doses are obtained. To illustrate: It is claimed by some that these small doses are potent remedies by reason of their frequent repetition; by others, that the method of

preparation, long continued trituration or succussion, and consequently thorough subdivision, accounts for their efficiency. Again, it is argued that small doses act by substitution—a theory which in itself is rather contradictory. Some who practice this method empirically would have us believe that no reason is needed further than the established fact of their almost universal success, while the homœopathic fraternity asserts that we are trenching on their domain; and last, but not least, the dosimetrists say that it is simply an attempt to reduce the practice of the healing art to a system of mathematical exactness, a work in which they have been enthusiastically engaged for the past fifteen or twenty years. A systematic review of these claims need not be undertaken here, as the intelligent and conscientious physician will have none of them, except that he will prescribe empirically remedies which he knows or believes will be instrumental in relieving suffering and curing disease. Better reasons, however, than either of the foregoing must be advanced before the majority of the profession will show a willingness to discard polypharmacy; and no doubt these will be forthcoming, but the inventor must be prepared to run the gauntlet of adverse criticism.

What I have to say at present will be confined chiefly to the therapeutic action and effects of small doses, referring incidentally to the physiological action in so far as the physiological effects point to the therapy, bearing in mind meanwhile that the physiological action of a remedy is modified by diseased conditions. Thus, in the use of electricity, it is well known that disease has the effect of reversing or transposing the physiological order of manifestations, as illustrated in the reactions of degeneration. Again, nitroglycerine is classed as a paralyzer, and we are taught that it may be given with advantage when it is desired to paralyze the vasomotor system: a fallacy which requires no further investigation than a reference to the cases in which it has been used to restore apparently moribund patients to life, as in the case of opium narcosis, asthma and other conditions which need not be mentioned. The actual results are not in accordance with theory, and the deductions of experimental physiologists fall to the ground. It has been said that, "The most effective way to explode a popular fallacy is to explain it," and nitroglycerine and electricity appear to offer special inducements. Macaulay is accredited with the observation that, "As the world gains in exact knowledge it must lose in imagination; the moonlight of fancy giving way to the sunlight of fact, and the creative faculty yielding place to the spirit of investigation or criticism."

Physiology, like politics, makes strange bed-fellows. Strychnine, said to be a stimulant to the nervous system, is in reality, not a stimulant at all, and we are taught that in the case of the ingestion of a lethal dose of this so-called stimulant, with the appearance of tetanic spasm, that its congener, electricity, another pseudo-stimulant is barred, as although the spasms are overcome, the patient dies. Under the same conditions, section of the spinal column overcomes the tetanic rigidity, but the unfortunate sufferer is as effectually paralyzed as when electricity is used. On the other hand, nitroglycerine, which in some respects acts in an opposite way to that of strychnine, stimulating the entire vascular system, and even raising the dead, to all intents and purposes, is classed as a paralyzer. Electricity, which is daily reaping its victims in connection with electric lighting, now known to be a potent remedy in extra-uterine pregnancy, and acknowledged even in small medicinal doses to act as a paralyzer when long continued, has long been regarded as a stimulant, and such is its present position. As a correlator of nerve-force it kills, a paradox difficult to understand.

In defence of the tenets held regarding electricity and strychnine, it may be suggested that the action of these remedies in small or medicinal doses is different from the action when large doses are used, a claim which would endow them with an unusual degree of fugaciousness, wholly unsupported by the facts. The truth seems to lie in the direction of limiting the physiological action of a remedy to one positive and distinct line of manifestations in health, the effect being modified by an increase or diminution of the dose, or by "the inter-action of the different parts of the body on one another" (Brunton). In disease, the action of the remedy will depend upon the pathological conditions present, and the tissues or organs affected may be acted upon in a manner similar to the physiological action in health; or the reverse may be true. Thus, Ringer says: "Strychnine affects paralyzed sooner than unparalyzed muscles;" but the fact is that strychnine does not affect the muscle in the least directly. The muscles supplied by enfeebled nerves are the ones first to show twitchings and spasm from both strychnine and the electric current, and were these agents true correlators of nerve-force it is only reasonable to suppose that their stimu-

lating action would first be observed in muscles supplied by healthy nerves. Let this serve as food for thought, a subject for investigation or criticism, and possibly the fallacy may be exploded by explaining it.

Were I disposed to enter upon an investigation of the physiological action of drugs, no better text could be found than the general principles laid down by Brunton, as indicated by the following catch-words: The interaction of various functions, direct and indirect action, local and remote action, relation of effect to quantity of the drug, dose and mode of administration, cumulative action, the preparation—pills, powders or liquids, effects of fasting, habit, temperature, season, climate, and time of day. Dr. Brunton also says (page 37), "The attempt to ascertain the precise mode of action of a drug by its *simple* administration, either to a healthy man, or to healthy animals, and observations upon them, is hopeless." Our great object, then, in the practice of the healing art, is to determine the uses and value of remedies as applied in the treatment of disease: clinical therapeutics. The secret of successful therapeutics is in knowing the effect of drug action in disease, and in understanding the demands of the economy in the case of complications.

This brings me to the question in hand: Can the use of small doses be explained upon any reasonable basis in accordance with modern physiological laws, with pathological changes as a factor to be taken into consideration; or shall the method be condemned as on a par with the late sensational announcement of M. Luys, concerning the alleged action of "*Médecines à distance?*" The readers of this journal are no doubt familiar with the conclusions of the commission appointed by the Academy of Medicine of Paris to investigate the truth of the report, and it is to be hoped that my views, although novel, yet not altogether new, may prove more substantial than those of the fanciful Frenchman.

The following extract from a clinical lecture on "Lithæmia with grave nervous symptoms" (Reporter, May 5, 1888, page 573), has been re-arranged and slightly modified to indicate the direction taken in the course of my investigations. The words in italics are my own; those enclosed in parentheses form a portion of the lecture as it originally appeared. While the changes are but slight, and do not fully elucidate my theory, there is a marked difference as to the assumed pathological conditions and the train of circumstances leading up to the ultimate objective symptoms. The case under consideration is that of a patient suffering from right-sided convulsive seizures—consciousness being unimpaired—denominated "hemi-spasm."

"Their occurrence *may be* (is) ascribed to the irradiation of powerful *occult influences* (motor impulses) proceeding from nervous centres, which are kept in an almost constant state of irritation and excitement by the morbid condition of the blood which *fails to nourish* (nourishes) them. From time to time there occur periods when defective coördination between the great abdominal viscera, the kidneys, liver and stomach, is followed by serious vitiation of the blood. The processes of secretion and excretion are interfered with or temporarily suspended, and the blood becomes loaded with effete products which, when in sufficient quantity, quickly manifest their power of exerting an actively poisonous influence, *destroying nerve-function.* The nervous centres, bathed in this toxic fluid, become intensely irritated; they become even more morbidly sensitive than usual, until finally, when nervous *control is suspended,* (tension has reached a point beyond which it cannot go,) there is a sudden explosion of force manifesting itself in these violent muscular contractions. At such moments, comparatively slight causes are sufficient to overthrow all *controlling* (inhibitory) influence, and give free reign to these irregular exhibitions of *muscular* energy. In this particular case these phenomena are brought out with exceptional clearness."

Having these observations before us, let me now proceed to examine the action and the effects of the three remedies already mentioned.

Nitroglycerine.—In the previous paper the types made me say this remedy in drop doses every five or ten minutes might be given for the relief of certain kinds of headache. Of course, the one per cent. solution was the preparation referred to, instead of the pure article. Exception has been taken to this recommendation on the score of its not coming within the category of small doses, and to a certain extent this is true. A few words of explanation, however, will serve to set the matter in its proper light. Five years ago a gentleman over sixty consulted me for a headache which had persisted for several weeks, although constantly under treatment. He was ordered to take that evening before retiring one drop of the one per cent. solution, in water, every five minutes, until six doses had been taken. He did this, and the result was that he felt all right the next morning, although later in the day the same symptoms showed a disposition to

return. Accordingly, the medicine was repeated the following evening, with perfect and permanent relief. Some years ago a medical friend related to me his experience in a similar case. The patient was a young man, and was put under treatment in the office one afternoon. In the course of an hour and a half fifteen drops of the one per cent. solution were administered, when the patient experienced a sensation as if something in his head had cracked, causing a loud report. The headache had vanished, and no bad effects or unpleasant sensations remained. Last autumn I saw a gentleman with phthisis pulmonalis, who had not slept an hour, night or day, for twelve weeks, on account of cough and irritable condition of the throat. From eight o'clock in the evening to ten, he took eight drops of the one per cent. solution, and slept comfortably all night, except that he was awake several times; but there was no troublesome cough. Instead of rising at daylight, as was his custom, he lay abed that morning until nearly nine o'clock. He spent a very comfortable day, and has not had any serious trouble with the throat since. This occurred last November, and the year preceding that time he had been under the care of four different physicians who had signally failed to relieve him. Large doses, five drops every three hours, are recommended by Dr. W. John Harris (*Therap. Gaz.*, May 15, 1888) in tubal nephritis with fever, dropsical effusion, and albuminous urine with tube casts.

Small doses of nitroglycerine may be given with great benefit in the case of embarrassment of the respiration and cough accompanied by a feeling of constriction about the throat in acute and chronic catarrhal affections (bronchial), in catarrhal pnemoniua and in catarrhal phthisis, either with or without profuse expectoration. Two, four or six drops of the one per cent. solution should be added to four ounces of water and a teaspoonful taken every two hours. An elderly woman suffering from catarrhal pneumonia of long standing, accompanied by constant hacking cough said, the day following the use of this solution, that she thought she had a new throat, so great was the relief. It will be observed that the dose here is 1-1600, 1-800 and 1-500 drop respectively, quite small enough to satisfy the most exacting.

An interesting case occurred to me a few months ago. The patient, a laboring man, or superintendent in a factory, had been suffering for more than a year from pain and stiffness in the muscles of the back of the neck, along with an unpleasant sensation in the occipital region. He said the pain in the head felt as if some one had taken hold of the brain and was twisting it around. His trouble was for the most part constant, as bad in the morning as at night, and was not influenced by taking food. After this long siege, and having gained no relief from the ministrations of several physicians, whose directions he had religiously complied with, he came to me. One drop of a one per cent. solution of nitroglycerine three times daily caused the pain to vanish in two days, and at the end of a week the medicine was discontinued. I should add that for the first few days the medicine affected him rather unpleasantly for the period of half an hour after each dose. Several weeks later this gentleman took a bad cold, which caused a return of the head trouble to some extent; but it was of short duration and was fully relieved by half-drop doses three times a day.

Now, assuming that pain is an expression of impeded and imperfect nerve energy, rather than of heightened nerve function, this remedy acts as a vaso-motor stimulant, increasing the supply of blood to the affected nerves, and by this simple means extinguishing their hungry cry (Valleix). In the case of lithæmia cited, we have seen how the sensibility of the nervous system may be obtunded to such an extent as to cause violent muscular contractions. At other times this abnormal condition may manifest itself in the shape of pain. How often do we witness subsultus in low fevers, twitching of the muscles, rambling and delirium, all due to depression of the nervous system, relieved by suitable pabulum in the shape of stimulants, or held in abeyance by calmative hypnotics or anodynes. These observations clearly point to the corectness of the theory that the function of nerve-force is not to stimulate, but to restrain and control muscular activity, a matter which will be more comprehensible when we consider the uses of electricity and strychnine.

[TO BE CONTINUED.]

AMENORRHŒA AND ITS TREATMENT.

BY WILLIAM B. DE WEES, M.A., M.D.,
SALINA, KANSAS.

The absence of the menstrual flow in a woman in whom it should naturally exist constitutes the symptom known as amenorrhœa. This term is, however, also applied to designate the absence of the catemenia for a considerable time after the regular

monthly epoch, in a woman who previously menstruated regularly. Thus we have, technically speaking, two great varieties of amenorrhœa, as commonly reckoned: (1) emensio mensium—when there is complete absence of anything like menstruation for a long period after the usual time for its appearance; (2) suppressio mensium—when the catamenia are obstructed in their regular periods of recurrence, in a woman in whom menstruation has been established.

Amenorrhœa is not a disease, but a symptom of a great many abnormal conditions of the system, the chief of which is chlorosis. This chlorotic state, as the fundamental cause of amenorrhœa, is of great frequency among women who live luxurious and indolent lives, and in this way disorder the nervous system and the circulation. Hence we encounter it for the most part among women in the higher and more wealthy classes of civilized society. Chlorosis is to be easily recognized by the whitish-green hue of the skin of the patient, the absence of a red color in the lips and mucous surfaces, the presence of languor, listlessness, depraved appetite and impaired digestion, constipation, palpitation, etc. There are also other symptoms and physical signs of serious systemic disturbances, among which may be mentioned a bellow's sound, heard almost invariably over the heart. This murmur is continuous in the larger arteries, especially the carotids and subclavians, and is reinforced by each systole of the ventricle. This sound is very similar to the *bruit* coincident with enfeebled circulation, as after copious hemorrhage. The blood when drawn from a vein is thin, light-colored and deficient in red corpuscles and in iron, while the clot is less proportioned than in health, etc.

The best method of treating amenorrhœa (emensio-mensium) is a very important matter. The true physician, having for his highest ambition "to aid nature," when called upon to treat amenorrhœa, must keep in view the cardinal points of his compass. He must keep in view first and foremost the three elements which must exist in a perfect state of health for the normal performance of the function of menstruation, viz.: 1. The ovaries, uterus and vagina must be normal in form and vigor. 2. The nervous system governing the relations between these organs must be perfectly healthy. 3. The blood must be in its natural healthful state, both in quantity and quality.

It will thus be seen that amenorrhœa is the symptom of a disordered state of one or more of these three elements, regardless of what the varied and numerous causes producing this disordered state may be; and that to successfully treat such cases, it of necessity requires the removal of the causes producing the disordered state, and in the next place to aid nature in restoring lost function.

The very first step, then, in the treatment of these cases is to be satisfied by a thorough examination as to the condition of the organs involved. Being satisfied in this particular, the second and third elements are to be studied simultaneously, since whatever benefits and improves or invigorates one effects the other proportionately. Thus we may first place at the top of our programme good, wholesome, nourishing and easily digestible and assimilable food. Milk, fresh beef, bran bread, eggs and fruits must form the greater portion of the dietary. Next in the order of importance are hygienic influences in the strictest sense of the term. The patient should pass as much time out of doors in the fresh air and sun-shine as possible. The danger is in the house, and not out of it. Regular and systematic bathing followed by a thorough rubbing—sea-bathing is preferable; exercise of any and all descriptions on foot, on horse-back, by rowing, calisthenics, etc., the association of cheerful and pleasant society, change of scenery and climate, overland route or sea-voyage, etc., and last but not least, early retiring to bed in the evening (9 o'clock) and early rising in the morning (5 o'clock). These principles strictly carried into execution would in the large majority of cases probably prove all that would be necessary to aid nature in making full restoration.

But do what we may, it is impossible to secure harmonious action on the part of these patients as a class, in executing the instructions fully; hence we are forced to resort to medication as an adjuvant or auxiliary to the treatment. Just here is where a large portion of the practitioners are forced to hesitate, as to the better remedies or combination of medicines to be prescribed. In this connection I beg leave to say that I have treated no less than several hundred cases of amenorrhœa, of the two varieties above defined, and while I founded the management of all my cases upon the foregoing general and fundamental principles of treatment, I have used in addition, in a large portion of my cases, the following medication, and am unable to recall a single case in my experience in which the treatment was not crowned with success. I first prescribe:

℞ Liquor ferri et quininæ citratis .....f℥j
Liquor potassii arsenitis.....f℥iij
Atropinæ,
Strychninæ.....āā..gr. ss
Elixir aurantii q.s. ad.....f℥viij

M. Sig.—Teaspoonful in water, before meals, three times daily. The ingredients or dose to be increased according to the tolerance of the patient.

This is continued in cases of emensiomensium, until there is manifested the peculiar menstrual malaise, or some slight show, when I discontinue it and prescribe:

℞ Potassii permanganat..... .....gr. x
Ft. pil. No. x, compressed or in capsule.

Sig.—One pill followed by one-half glassful of water before meals, three times daily.

Also:

℞ Manganesii bin-oxidi.....gr. x
Ft. pil. No. x, compressed or in capsules.

Sig.—One pill after each meal, three times daily.

By the second or at most the third day after taking these, the flow usually becomes fully established. If the manganese does not fully effect this at the first attempt, we have, however, a stated period from which calculation can safely be made for the next period. The first prescription is relied on during the interval, and the pills commenced about three days before to the expected time.

In cases of supressio mensium, I usually simply rely on the permanganate of potash and bin-oxide of maganese as just stated, and have found the combined use of these two salts all that can be desired for an emmenagogue. The first is a direct emmenagogue, stimulating the uterine muscular fibre; and the latter is an indirect emmenagoge, improving the blood and toning up the nervous system. I have in a number of cases of strong, robust and large women, used these salts in two grain doses. In two patients, who were women of culture and refinement, wealth and influence, I was repeatedly assured by them that they were positive of no conception having taken place, but after three days use of the drug in one case, and four days in the other, I was in both cases hurriedly summoned. I found them in a high state of fever, 102° and 103° respectively, with quick pulse, emesis, spasmodic and painful contractions of the uterus, diarrhœa with some tenesmus, frequent micturition with attendant strangury, a flushed and hot surface of the entire body—indeed the skin in the face assuming an erysipelatous blush. The conjunctiva was congested, the pupils somewhat dilated. I gave a hypodermic injection of morphia to allay the irritation, which it gradually accomplished, and the alarming symptoms subsided, with the exception of the uterine contractions; these continued, but with comparatively little pain until the following night, and then finally ceased after bringing away a two months embryo in the one case, and a three months embryo in the other case. The drugs had been administered three days in the first and four days in the second case, in doses of two grains each. The period of gestation was afterward fully acknowledged by each mother respectively, who also confessed that they had designedly concealed their pregnancy with the purpose of obtaining a miscarriage. This result must be attributable to one of two things: Either it was due to an untoward effect or physiological action of these drugs. Idiosyncrasy is out of the question, since both these women had been treated before with permanganate of potassium, and other drugs separately, by several physicians with no effect whatever. Or, on the other hand, there must be an action resulting from the combined administration of these two drugs, which produces a peculiar or more powerful effect, than either of them does when administered alone. For in these two cases they proved true ebolics, for I have never witnessed such a peculiar and powerful oxytocic action from ergot or any drug, and it persisted even after morphine had been duly administered.

PREPARATION OF MILK IN SUMMER.

BY E. A. WOOD, M. D.,
PITTSBURGH, PA.

The time is here for the summer complaints of childhood. Thousands of children were lost last year—shall the Angel of Death again cast his annual shadow over our homes? Have we learned anything since last year, and are we more competent than ever to stay the slaughter of innocents—the slaughtering that is a disgrace and a crime? Do we know of even one thing, trifling though it be, that shall assist in carrying children through the perils of the heated term now on us? That others may be encouraged to publish the facts and opinions in their possession bearing on the subject, I offer one small suggestion on the subject of infant feeding.

When human breast milk cannot be had in any case, procure the best cow's milk; get it fresh morning and evening; keep it in a cooler in which nothing else but ice is kept; keep that cooler out of doors in the shade, or in an open hall or room, and not in a closet, pantry or cellar. Take one pint of milk and divide it in two equal parts;

separate the curd from one-half, either by heat or by heat and calf's rennet—the latter preferably, because it not only more quickly separates the whey and the curd, but rennet is a real digester, and better than any artificial pepsin. Take the whey so separated, add it to the other half of the pint of milk, and feed as the child needs.

Several modifications will suggest themselves to the intelligent practitioner. Those who have faith in *pepsina porci* may use it to partially digest the whey milk. When this is done, the whey milk should be boiled to stop complete digestion. My experience is that fresh milk from grass-fed cows is more easy of digestion without being boiled. When the milk is not of that kind, and to destroy bacteria, it is perhaps better to boil it. The thing I wish to bring to notice is that weak stomachs can digest milk containing *half* its curd, but cannot digest all the curd. Life is too short to spend in arguing the advantages of whey over water as the diluent of milk. Those who cannot feel the force of such a procedure should continue to use water to dilute cow's milk. Milk whey has gone out of fashion, but whey will come in again, not as a fashion, but as food commending itself on principle and practice.

Milk whey is a much better fluid than water to add to the many preparations of beef in the market. Try it.

Every practicing physician should have a small food laboratory at his home, where he can experiment, and learn for himself the behavior of foods, and how to modify them for the requirements of his patients.

Society Reports.

PHILADELPHIA COUNTY MEDICAL SOCIETY.

Stated Meeting, May 23, 1888.

Therapeutics of Diphtheria.

In opening the discussion on Dr. Jacobi's paper (see pages 797, 829), and on Dr. O'Dwyers (see page 806),

Dr. William Pepper said: The evening has been so well occupied in listening to the two important and unusual papers—to me most instructive—that there remains little to say in the way of discussion, save as to courteous appreciation of the kindness of our visitors and of our debt to them. I rise, then, simply to express our appreciation of the great wisdom of the advice to which we have listened. In regard to the last paper, I wish to add my mite of evidence to the value of the operation introduced by Dr. O'Dwyer. It is destined to fill an important place for these reasons, if for no others: that you can induce parents to assent to intubation, when it is impossible to secure their assent to tracheotomy; that in very young children in whom, as we know, tracheotomy is so difficult an operation, intubation can be performed with great facility; and finally, in septic cases, here is an operation for restoration of breathing space by means of an artificial air-tube which does not involve an abrasion of the surface to tempt extension of the infectious process.

From the masterly address of Dr. Jacobi, I am sure that every person present has derived much instruction and much pleasure—stamped, as it has been from beginning to end, with the accents of earnest truth, with the richness of practical experience. It is precisely these details to which Dr. Jacobi has called attention, that are of the highest importance in the issue of our cases. If he had done nothing more than warn us of the danger of relying too implicity upon trained nurses, he would have done a service. As with every new instrument of precision, after its value has been demonstrated, comes a period in which there is a dangerous tendency to rely upon it too exclusively; so with trained nurses, if we trust too implicity to their unsupervised discretion, we are consigning our patient to more vigorous, and, therefore, more dangerous ministrations—because equally unskilled—than the untrained solicitude of parents and friends. And this must continue to be the case until a longer and more thorough course of study is insisted upon. So, too, with the high importance of a radical treatment of antecedent and neglected—because apparently trifling—lesions, which the lecturer has emphasized. It is well for us to bear in mind the warning that tonsillar hypertrophies, nasal catarrhs, and the like may tempt the localization of diphtheria, and I may add of scarlatina and of measles in time of epidemic.

The extreme value of iodoform in local treatment I can confirm. Soluble in ether, miscible with glycerine and with oils, capable of use as powder, it is the best of all local applications, and may be applied to all cases and conditions. I would, however, interpose a mild protest against the too sweeping condemnation of the steam atomizer. Used with that gentleness, so wisely insisted upon, and the confidence of the child obtained, the relief to oppression is so soon recognized that we can secure intelli-

gent coöperation in its frequent and regular use. The problem of internal treatment is the most difficult one, a problem which largely and continually occupies our thoughts. I have been glad to hear Dr. Jacobi's clear and outspoken adherence to the mercurial treatment, although he limits it to a certain group of cases. My longer experience has but abundantly confirmed my early impressions of its value—preëminently in laryngeal diphtheria whether primary or descending; and I am constantly impressed with the tolerance of children to the bichloride, and equally to the mild chloride. But I would go further than the lecturer. If in a form conspicuous as a dangerous one, which is usually not primary, but associated with rhinitis and faucitis, this treatment proves efficacious, why is it not equally good where the nasal or faucial disease has not extended into the larynx? I have found cases of nasal diphtheria which were a source of great anxiety yield in a most remarkable way, and it has seemed to prevent the local spread as well as septic infection.

I agree with Dr. Jacobi that it is well to begin treatment with the chloride of iron, and that the association of chlorate of potassium is a matter of comparative indifference, and that large doses should be given at short intervals. But I have not been so fortunate in seeing it usually well borne by the stomach. When gastric or intestinal irritation manifests itself, it is well to stop the iron abruptly and to substitute mercurials. Or, when in the beginning of a case the glandular involvement, the faucial tumefaction, the constitutional symptoms, give evidence of rapid sepsis, we cannot depend upon iron and must give the corrosive or the mild mercurial chloride at once.

In an address covering so wide a field there is much room for difference of individual experience. In threatened heart failure, I would appeal for the early administration of strychnine, which I place above digitalis or sparteine or ammonia, above everything but alcohol. These are but slight observations on a subject opened with a breadth and discussed with a richness for which we cannot sufficiently express our admiration.

Dr. Carl Seiler: I have only to say that in my experience the addition of chlorate of potassium to the chloride of iron has been of great use, although I agree with Dr. Jacobi that chlorate of potash alone is of little use. From laboratory experiments I attribute this to the disengagement of chlorine gas when the two solutions are mixed.

I see that Dr. O'Dwyer has added an artificial epiglottis to the tube. It has been the experience of all laryngologists to meet with cases of complete or almost complete destruction of the epiglottis by syphilitic or other ulceration, in which there has been no difficulty of deglutition at all. Therefore I long ago came to the conclusion that it is not the epiglottis which protects the larynx, but the apposition of the ventricular bands. And I would suggest, though I have no experience with such a device, that if the tubes were so made that the head could slip into the ventricles of Morgagni without interfering with the ventricular bands, there would be no difficulty in deglutition experienced. It is not only in New York, but also in this city, that the only operation for opening up the air passages that parents will consent to, is intubation. I recall a very distressing case in an asylum, in which the matron would not consent to tracheotomy until the mother of the child had been communicated with, and while they were hunting the mother the child choked to death. This was before we knew of intubation. That we might have performed at once.

Dr. H. R. Wharton: The hour being so late I must postpone what I had intended to say concerning some of the complications of intubation. As to the calibre of the tubes, the fact that children do breathe well with tubes as now made, is sufficient evidence of the correctness of Dr. O'Dwyer's position. Since my experience of this, I am not so anxious as formerly to get in the largest tracheotomy tubes.

Dr. E. E. Montgomery: Since August, 1886, I have performed some thirty or forty intubations, having previously done some twenty-eight tracheotomies. Fifty per cent. of the children intubated have recovered. My experience is that this operation largely reduces the necessity for tracheotomy, and I believe that if intubation were done early in every case, tracheotomy would rarely be necessary. I cannot refrain from saying that I feel that in devising and perfecting his operation, Dr. O'Dwyer has been a benefactor to the medical profession and to the human race.

Dr. M. Price: In the evolution of steam from lime I have for the last fifteen years depended upon the same method as country people use in the scalding of hogs. Put a few pieces of lime in a bucket with hot water, place a blanket over the bed and let steam pass over the child's head. Soon the child acquires confidence and asks for relief, and will even bend his head down over the

bucket trying to get the vapor into his throat. Now, if every half hour a hot stone or brick or piece of metal be added to the water, it will keep up the heat without any stove or fire being needed in the room. It keeps the room clean and the atmosphere sweet. I have not found so much danger of contagion when lime is used.

I show here a specimen of tincture of chloride of iron in syrup, which is well made and of the proper color. There are very few drug stores in which you can get it properly made, and if you don't get the right thing it is of no service whatever. Its greatest good is in its local effect.

Dr. Shimwell: I have performed intubation sixteen times with seven recoveries. In all there has been immediate relief to respiration. In one case I had to remove the tube twice, and introduce it three times, and perform artificial respiration. In removing the tube post-mortem, I have found it impossible to drag it down through the trachea, so there is no danger of slipping. Is not the occurrence of substernal respiration-depression rather too late an indication to wait for?

The President, Dr. J. Solis-Cohen: I have listened with pleasure and with profit to both these papers; and with all the study that I have given to this subjeet, I have gained information to-night on many points. The advice to give early attention to the heart, that when danger already threatens it may be too late to effect anything with remedies, is advice that we should all take to heart. We have been distinctly taught that the prevention of this complication must be from the beginning an integral part of the treatment.

In regard to local treatment my experience has differed from that of our distinguished guest. Where it can be properly applied to the extreme margins of the pseudo-membrane I have found that the topical use of chloride of iron, by firm and gentle pressure with brush, or, preferably, cotton wad, the most serviceable agent I have used. The drug has an astringent and a disinfectant action, and I am satisfied that I have time and again seen it assist the detachment of false membrane, and apparently prevent the extension of the infection. Concerning the value of chloride of iron internally, the importance of large and frequent doses, the advantage of mixture with glycerine to assist its local effect, I can only confirm what has been said. So, too, as to the bichloride of mercury; I am glad to hear its great usefulness emphasized, and, with Dr. Pepper, I would include all forms of the disease in the field of that usefulness. Empirical observation has long taught us the preëminent value of the chlorine compounds in general in the treatment of diphtheria; and the mercury chlorides, more particularly calomel, however, have always enjoyed a high reputation in the internal treatment of membranous laryngitis. It has pleased me, in these discussions, to hear reasons at least plausibly advanced in explanation of facts which our forefathers learned and used empirically; this is the true direction of medical progress. The topical action of steam is very important. It has always seemed to me that in the natural course of the disease the membrane is thrown off by an accumulation of fluid beneath it which softens it and secures its detachment. We aim, then, by furnishing artificial moisture, to imitate the natural process of recovery. And this leads me to speak of the value of the vapors from lime in the process of slaking. Using a large wash-tub or wash-boiler, and keeping up a supply of large pieces of lime, we secure an abundant disengagement of the hot vapor of water, carrying up with it particles of lime, which mechanically assist by prying up the edges of the pseudo-membrane, and thus favoring the access of the vapor of water beneath it.

There is another method of local treatment which I employed with great satisfaction, more especially in former years, when I saw more of the disease—that is, inhalation of carbolic acid in the spray of a steam atomizer, in very large doses. Twenty to twenty-five grains would be added to the ounce of water, and from half an ounce to an ounce sprayed into the throat every hour, or even half hour, until commencing discoloration of the urine gave evidence of saturation, when the remedy was to be stopped until the urine again became clear. Under this method I would advise the attending physician to see the child four or five times a day, always having the urine last voided saved for him, and when the olive discoloration is noticed to intermit the carbolic acid. This seemed to me to disinfect the system, and thereby improve the local condition, and, at the same time, to prevent or diminish the danger of systemic sepsis. I was not aware, before to-night, that such small doses of carbolic acid as Dr. Jacobi mentions, could be of service.

I must repeat our sincere appreciation of the obligation under which Dr. Jacobi has laid us by his masterly paper. I am also glad to thank Dr. O'Dwyer for his lucid exposition founded on fact, and proved by actual exhibition of specimens, that the small calibre of his intubation tube is amply sufficient for due respiration. My own experience

with tracheotomy has led me to favor large tubes, the largest that can be introduced without touching the walls of the trachea. I still believe that I have seen life saved by taking out small tubes and substituting larger ones. And I confess that the small calibre of the tube used was one of the theoretical considerations which I enumerated among the drawbacks to intubation. But facts are stronger than theories, and as the small calibre intubation tube does seem to give air enough, and as enough is all that is wanted, I am ready to profess my satisfaction with its present calibre.

I must ask Dr. O'Dwyer to make clear to us the question as to the impaction of membrane. This is not a mere theoretical objection, but is borne out by experience. Perhaps I have been led to attach an undue importance to the matter by an accident which occurred to me a year or so before Dr. O'Dwyer read his now historical paper before the International Medical Congress at London, in 1881. I had been called to a case of membranous laryngitis, and had proposed tracheotomy, which had been declined. As I turned to leave the room the mother called piteously, "Oh, doctor, don't leave my child without trying to do something for it." I said to my assistant, "we will try to save this child," and taking a catheter I cut off the end, and passed the instrument into the larynx. The child instantly became black in the face, and there was nothing for it but, without asking any questions, to plunge my knife into the trachea as the child lay on its mother's lap. I inserted the same catheter through the orifice deep into the trachea, and then we performed artificial respiration; my assistant inflating the child's lungs through the tube with his own breath, and my hands exercising compression of the thorax in respiratory rhythm; and, after a while, we had the satisfaction of leaving the rescued child sleeping peacefully with unobstructed respiration. But I confess that this experience cost me some of the most anxious moments of my life, and has left a fear of the danger of crowding down membrane in front of a tube introduced into the larynx, which may, perhaps, make me overanxious.

Dr. Jacobi, in closing the discussion on his paper, said: The slaking of lime has the further advantage that it is the only way to utilize lime. A lime-water spray is useless, but in slaking, a large amount is carried up into the air and air-passages.

The suggestion of the President, that carbolic acid should be used in spray until discoloration of the urine is noticed, I do not feel inclined to adopt. Diphtheria is the very disease in which no complication should be allowed to exist, and we must not tempt them. A single case in which we should have to blame ourselves for a possible nephritis would, in my judgment, condemn the treatment. Besides, young infants are sometimes poisoned by very small quantities.

Dr. O'Dwyer, in closing the discussion on his paper, said: Pushing down of membranes does occur, though rarely. The difference between the liability to the accident in catheterization and intubation, is that the catheter has an open, comparatively broad end, while the intubation tubes are comparatively probe-pointed. One pushes and catches the membrane, the other slides past it. I have crowded membrane down in only two cases out of two hundred sufficiently to produce asphyxia. In those two, on removal of the tube, the cast was coughed out.

If we take away the tube because the child is breathing badly and the trachea is full of membrane, the child not having the strength to cough it out, the child chokes from the absence of the tube, not from its previous presence. My attention is now being directed to devising a means to get rid of the membrane. I hope to present something practical before long.

Blocking with membrane while the tube is in may occur. Formerly, when the swell of the tube was not so great, it would be coughed out, but now it is not coughed out, and suffocation may take place. The original tube was better in this regard. The earlier tubes were made to fit into the ventricles with the idea of permitting the approximation of the ventricular bands, but it did not work. It is true that the epiglottis is merely an accessory, but in an intubation case the ventricular bands being held open we have to depend upon it; and that is the reason, the dependence being a poor one, that solids and semi-solids which can go down in mass are better than liquids.

MEDICAL SOCIETY OF NEW JERSEY.

ONE HUNDRED AND TWENTY-SECOND ANNUAL MEETING, SCHOOLEY'S MOUNTAIN, N. J., JUNE 12 AND 13, 1888.

First Day, Tuesday, June 12.

At four o'clock, P. M., on Tuesday, June 12, the Society convened in the large parlor of the Heath House, Schooley's Mountain.

The meeting was opened by prayer, by the Rev. Hugh Smythe.

The calling of the roll showed about one hundred delegates present, and the number in attendance was increased by the presence of many visitors. Among those who were formally received by the Society as its guests were: Dr. Adam C. Deane, of Massachusetts; Drs. Bulkeley, G. Grant, Gibney, Tanner, and Morrow, of New York; and Drs. Packard, Seiler and De Forest Willard, of Philadelphia.

The afternoon session was devoted to routine business, the appointment and the reports of committees. The Society was welcomed to the mountains by Dr. J. G. Ryerson, who spoke of the value of the mountains as dispensers of pure air and good health to all comers, and pointed expectantly to the time when the villas on the mountains would be as the sands, or the cottages on the sand, of the sea. He spoke of the appropriateness of this visit of the oldest of the State Societies to this, the oldest of the health resorts.

After a short adjournment for dinner, the Society convened at 8 P.M.

Dr. John W. Ward, of Trenton, delivered the President's address. His subject was the

Responsibility of the Insane.

He urged the importance of the medical factor in determining the accountability of those pleading insanity as an excuse for crime. The term "mental disease" is unforunate; insanity is not a disease of the mind, but a disease of the brain—a physical disease. In marked cases it does not need an expert to tell that the mind is deranged; but there are cases in which the disease is so subtle as hardly to be recognized by the victim's intimates until some untoward act is perpetrated. In these cases medical opinion alone is of value in determining responsibility.

Between that psychological condition which elects to do evil instead of good, and which does this the more readily because of heredity, education and surroundings, and mental derangement due to diseased brain, there is a line to be drawn, and upon this line rests the question of responsibility. Neither the popular idea that insanity transforms the individual, nor the legal idea that insanity is some mysterious abstraction that renders the individual powerless to reason, is correct.

He then gave a historical review of the many theories regarding insanity, and their effect upon criminal laws and judicial decisions. Coming down to modern times and quoting Chief Justice Hornblower's ruling in the Spencer case, "that the burden of proof of insanity is on the accused, and whatever the amount of insanity present, if he is conscious at the time of committing an atrocious act, he is guilty in the eyes of the law," Dr. Ward said: such rulings are not right. Insanity is not a question of metaphysics or of morals, it is a question of disease. The insane act from well-defined motives, and are influenced by passions and by revenge, in the same manner as the sane are. A delusion or hallucination is a reality to him who is thus affected. The pivotal point on which responsibility should rest is the dependence of the criminal act upon the insanity of the individual.

Insanity in these cases consists, not in preferring vice to virtue, in applauding crime and deriding justice, but in being unable to discern the essential identity of nature between a particular crime and all other crimes, whereby they are led to approve what in general terms they have already condemned. Dr. Ward advocated the establishment of a Board of Experts to advise with a court in all such cases, who should examine the case as medical men and officers of the court to determine insanity and responsibility.

The Standing Committee submitted a report founded upon the reports of the various district societies. It was exceedingly long, and portrayed the health of the State down to very minute details. It indicated that malarial diseases have steadily decreased all over the State, and that the physicians of the State have about the usual amount of contagious and seasonal diseases to combat.

Drs. Baldwin, Rodgers, and Quimby, discussed the question of the

Relation of Laundry and Dish-Water to the Spread of Disease.

Nothing particular was developed by this discussion.

Dr. Lehlbach opened the second subject for discussion,

What Treatment will Most Effectually and Promptly Curtail the Course of Acute Rheumatism?

with a paper which he summed up as follows:

First. It should be treated as early as possible, and the public should be educated to understand that we do know something about it.

Second. Rest at the incipiency of the disease is essential to the rapid curtailment of its course.

Third. Individualization in every case should be carefully observed, and each case

should be treated by itself, and routine avoided.

Fourth. Being a disease probably due to specific causes, probably microbic, it should be treated by such remedies mentioned as experience, both empirical and scientific, shows to be efficient.

The session adjourned at 10.30 P.M., to partake of a banquet served by the proprietors of the Heath House.

Second Day, Wednesday, June 13.

The third subject for discussion,

The Treatment of Phthisis by Gaseous Enemata,

was opened by DR. STICKLER, who gave an interesting *résumé* of cases which strengthen the general opinion of the profession, that the gaseous method is not a success.

The various reports of delegates to corresponding societies were then received, and addresses were made by delegates from other State Societies and by visitors from other places.

DR. JAMES S. GREEN, the third Vice-President, read a paper entitled

A Review of the Surgery of the Knee-joint for the Last Fifty Years.

This was a finished and thorough study of the surgery of the knee-joint; the various phases and methods of the different periods of surgical science, and especially the modern methods, were carefully described, and their respective merits discussed and compared.

DR. PACKARD, of Philadelphia, discussed the paper, giving his views of the technique of the operation by incision, the value of backward drainage through the popliteal space, and the operation of erasion for gelatinous degeneration of the joint. He also spoke of the difference between the conditions, when foreign bodies are introduced into a joint and when it contains loose cartilages and pus.

DR. WATSON was invited to describe to the Society the experiments of Dr. N. Senn, made before the Surgical Section of the American Medical Association on the diagnosis of intestinal wounds by the hydrogen gas tests.

DR. PACKARD, of Philadelphia, requested the attention of the Society to the question of the establishment of State Boards of Examiners in Pennsylvania and New Jersey. He considered that serving on such mixed boards was in violation of the Code of Ethics. He quoted that part of the code which referred to this part, and claimed that serving on such a board was acknowledging regular medicine to be a sect, and that granting them licenses to practice was recognizing homœopaths and eclectics as true physicians and recommending them to the public as trustworthy practitioners. Homœopathy to-day is just as much a system of quackery as ever it was. They take advantage of all advances made in scientific medicine, but have added and do now add nothing to it. They practice under a flag whose principles they do not adhere to. It is much better to wait action until it can be taken without opposing the code, which is the one bond of the medical profession.

DR. PENNINGTON said that the views of Dr. Packard were in harmony with those of a committee appointed a few years ago on a cognate subject, and were those to which he could willingly subscribe.

DR. LEHLBACH; after a lively speech of a few minutes, wherein he divided the adherents of homœopathy into two classes, those who know better, and those who don't, preferring the latter, presented the following resolutions, which were carried:

"*Resolved*, That the following questions should be submitted to the District Medical Societies for consideration during the coming year:

First, Is it in the interest of the protection of the public against illegal and unqualified practitioners that State Boards of Examiners should be established?

Second, What would be the proper and best way of establishing such Boards?"

The third resolution directed that the action of the County Societies should be reported to the State Society at its next meeting.

The Nominating Committee presented the following nominations for officers for the ensuing year, who were immediately elected: *President*, H. Genet Taylor, Camden; *1st Vice-President*, B. A. Watson, Jersey City; *2d Vice-President*, James S. Green, Elizabeth; *3d Vice-President*, E. J. Marsh, Paterson; *Corresponding Secretary*, William Elmer, Jr., Trenton; *Recording Secretary*, William Pierson, Orange; *Treasurer*, W. W. L. Philips, Trenton; *Standing Committee*, T. J. Smith, Bridgeton; D. C. English, New Brunswick; J. G. Ryerson, Boonton. Next place of meeting, Spring Lake. The date to be announced.

DR. BARKER exploded a small bomb-shell in the convention by introducing a set of resolutions regarding the Morris Plains Asylum. There was much discussion immediately, and, after the sense of the meeting had been pretty well developed, resolutions were passed as follows:

Whereas, The Morris Plains Asylum for the Insane has for the last three years been managed upon what is generally termed the "dual system;" and,

Whereas, That experiment has drifted into a state of things that has resulted in a legislative investigation of alleged mismanagement; and,

Whereas, The proper treatment of insane persons can be fully carried out only when the medical staff has entire control over everything that pertains to the bodies as well as to the minds of the unfortunates committed to their care: therefore be it

Resolved, That the Medical Society of New Jersey hereby expresses its unqualified disapproval of any system of management that takes the food, the clothing, or any other physical want of the patients from the care and control of the medical staff, where it properly belongs, and places it in any other hands.

Dr. H. M. Weeks was appointed essayist for the next annual meeting.

Dr. Davis reported from the special committee having the matter in charge, a proposed law for the regulation of dissections.

After the usual vote of thanks the meeting adjourned.

Periscope.

Exudative Peritonitis of Children.

In the *Archiv für Kinderheilkunde*, IX, 2, Dr. Max Hirschberg communicates eight cases of undoubted chronic tuberculous peritonitis, and four cases of a non-tuberculous nature, from Baginsky's polyclinic. The clinical differential diagnosis between the two forms is extremely difficult, frequently about impossible. In favor of the tuberculous form are: tuberculous disease in the lungs, testicle, bones, lymph-glands; associated with marked, steadily progressive emaciation, hereditary taint, redness about the navel, with eventually formation of abscess and the detection of tumors by palpation.

Treatment consists in the maintainence of the strength of the patient, and if possible improving it by the use of strengthening food, iron, cod-liver oil, extract of malt, etc. Then the absorption of the exudate is to be started by diuresis and diaphoresis, cold water or cold wrappings. Inunctions with mercurial and iodoform ointment are to be tried. We are powerless against the tuberculous process proper. The author thinks König's proposal of laparotomy with antiseptic washing of the peritoneum is worthy of further trials. Early paracentesis, as proposed by Fiedler, he thinks can for the most part be dispensed with, as the end can be achieved without it.—*Deutsche Medizinal-Zeitung*, March 15, 1888.

Removal of Kidney for Pyonephrosis.

At the meeting of the Imperial Royal Medical Society of Vienna, March 9, 1888, Dr. Weinlechner presented a patient from whom he had removed the right kidney on account of pyonephrosis. She was fifty-one years old, and had suffered for ten years with pain in the right side of the abdomen, and soon after the occurrence of the pain she noticed a tumor, which continued to extend downwards, and was of changing size. In periods lasting three weeks there were fever and violent pains in the tumor; during this time the urine was clear and the tumor became larger; at the end of the three weeks the urine became purulent, the tumor became smaller, and the patient felt better. These periods during the first five years were infrequent, but became constantly more frequent, so that the patient was never free from pain. When Dr. Weinlechner saw her he found in the lumbar region a tumor extending four finger's breadth from the symphysis; fluctuation was marked, and the lower border of the tumor was easily movable. The diagnosis of pyonephrosis was made, and nephrectomy by the extraperitoneal method done October 18, 1887. About one pint of pus was first removed, and then the tumor itself. Recovery was prompt. The urine rose in amount from 20 to 30 ounces, and reached, on the twentieth day after the operation, 45 ounces.—*Deutsche med. Wochenschrift*, April 5, 1888.

Dicrotism of the Pulse in Insufficiency of the Aortic Valves.

Geigel (*Deutsches Archiv*, Bd. 42, Heft 4, 391) reports an interesting case which shows that the presence of dicrotism in a compound valvular lesion is no proof that the aortic valves are not affected. The patient when first examined exhibited typical signs of pure aortic insufficiency, and her sphygmographic pulse-tracing was that characteristic of this affection. Later, a fresh endocarditis developed, and then signs of mitral regurgitation. A new tracing now revealed the presence of distinct dicrotism. The author explains this in the following manner: In simple aortic insufficiency the contraction of the arteries drives the blood back into the empty, dilated, and yielding left ventricle, and there is consequently no secondary pulse-wave, or, at most, only a suggestion of one. If now the

mitral valve becomes insufficient, the left ventricle drives a considerable portion of its blood during the systole into the auricle. The greatly distended and over-filled auricle then returns this at the very beginning of the diastole into the ventricle, and the ventricle, now on its part fully distended, offers a resistance to the mass of blood tending to regurgitate from the aorta. The secondary pulse-wave is, therefore, again produced, just as though the aortic valves were sound. It was interesting to note in the case reported that the endocarditis appeared later to heal, while the systolic murmur and the accentuated pulmonary second sound disappeared. A pulse-tracing taken at this time showed the absence of dicrotism as when first examined.—*American Journal of the Medical Sciences*, May, 1888.

Inversion of Abdominal and Thoracic Viscera.

At the meeting of the Edinburgh Medico-Chirurgical Society, April 4, 1888, Prof. T. R. Fraser exhibited a case of inversion of the abdominal and thoracic viscera. The patient was a woman, 23 years old, who came under observation suffering from the effects of over lactation. She had nursed her child for thirteen months, and was weak and debilitated. Palpitation coming on, she noticed that there was a "beating" on the right side. For this she consulted Dr. Johnston, of Leith, who on discovering the peculiar nature of the case, sent her to see Dr. Fraser. Percussion and auscultation proved the case to be one of transversion of the heart, the position of which could not be accounted for by any previous illness. On further examination it was found that the stomach and spleen were also on the right side, while the liver was on the left—a complete inversion of these organs. The patient is one of a large family, six of whom have been examined, and in all the position of the viscera is normal. It is also normal in the case of her father, mother, and the child, showing absence of heredity.—*Medical Press and Circular*, April 18, 1888.

Asserted Antagonism of Certain Poisons.

At the meeting of the Biological Society of Paris, May 12, 1888, M. Roger said that he had made some experiments in the laboratory of Bouchard for the purpose of determining if, as asserted, the lethal dose of a poison is modified by the simultaneous introduction of another poison. He selected for experiment morphine, atropine, quinine and chlorate of potassium. He, in the first place, determined the toxicity of the drugs when they were injected into the veins; the numbers so obtained represent what Bouchard has called the toxic equivalents. He then mixed two of these bodies and investigated their united toxicity. "I have proved," said M. Roger, "that with mixtures of atropine and morphine, the animal dies even before having received the toxic equivalent of one of the two bodies; this is also true of mixtures of atropine and quinine, and of quinine and morphine." In all these cases, he says, the two substances re-enforce each other in their action and their toxic powers were duly increased. He says he has proved that mixtures of chlorate of potassium and of quinine have a toxic power nearly twice that indicated by the sum of the toxic powers of the components. When the potash salt is added to morphine, each substance acts as though it were alone, and the animal dies when it has received the lethal dose of one of the two poisons. In no case has he observed a toxic antagonism, that is to say, a more or less complete neutralization of one poison with another.—*Bulletin Médical*, May 16, 1888.

Gouty Peripheral Neuritis.

In an interesting account of a case of peripheral gouty neuritis, in the *Bristol Medico-Chirurgical Journal*, March, 1888, Mr. F. W. Jollye gives the following symptoms as being in favor of his diagnosis of peripheral neuritis:

1. The pain remained limited to one side for some time before suddenly appearing on the other. 2. The lightning-like pains in the extremities, and the "pins and needles" in the fingers and toes. 3. The marked tenderness of several nerve-trunks. 4. The hyperæsthesia and wasting of the muscles of the extremities, accompanied by the R. D. 5. The vasomotor disturbances. 6. The paralysis beginning in extensors and spreading towards the trunk, and afterwards affecting to a slighter extent the hands and arms. 7. The decided intermissions of pain which the patient frequently enjoyed during the earlier stages of the disease. 8. The relief from pain during the attack of gout. 9. The retention of urine coming on as a very late symptom. 10. No affection of the mental faculties. 11. Absence of bedsores.

Remarkable Case of Aneurism of the Thoracic Aorta.

Dr. Byrom Bramwell, who reports this case in the *Edinburgh Medical Journal*,

April, 1888, says that the case is remarkable from the fact that the patient was able to follow his employment for at least seven years with an aneurism projecting through the front wall of the thorax. The notes show that the patient was a foreman, 48 years old, who in February, 1887, was found to have a pulsating tumor, fully the size of half a cocoanut, projecting from the front of the left chest, between the clavicle and the fourth rib. The clavicle was pushed slightly forwards and upwards by the base of the tumor. The skin over the tumor was thin, and already beginning to present the blue, glazed, shining appearance so suggestive of approaching rupture. There was very forcible pulsation all over the projecting part of the thorax, and the contents of the sac appeared to be fluid. In addition to the dulness in front, there was well-marked impairment of the percussion note in the left supra-scapular and infra-scapular and in the inter-scapular regions.

A systolic murmur was audible over the tumor, at the base of the heart, and over the left side of the back; the aortic second sound was accentuated. The heart seemed enlarged as well as displaced downwards. The left pulse felt delayed when compared with the right.

The patient gave the following history of his case: Some fifteen years ago, while making a powerful effort in helping to lift and remove a boiler, he distinctly felt something give way in his chest, and fainted. After this strain he suffered more or less from severe pain in the left shoulder, left arm, and upper part of the left chest. These pains were thought to be rheumatic. One winter's day (according to his wife, seven years previous to his death, but as Dr. Bramwell has it in his notes, eight years ago) he fell while clearing snow of the roof of his house, and struck his chest with great force against the projecting knob of an iron railing. He became very faint, and turned of a dirty green color. After this, a lump gradually formed at the upper part of the left chest—the seat of the injury. He consulted the late Dr. Houston, who diagnosed the condition as aneurism of the thoracic aorta, and sent him to the Edinburgh Royal Infirmary, where he remained for several weeks. In the Infirmary the diagnosis of an aneurism of the thoracic aorta projecting through the front of the thorax was confirmed, and the iodide of potassium was administered in full doses. Under this treatment and rest, the pains in the chest and shoulder were much relieved, but the pulsating tumor, which was, he says, at that time about the size of a hen's egg, did not diminish in size. After his discharge from the Infirmary he returned home, and, contrary to the advice of the doctors, went back to work. He continued to follow his employment regularly until January of the present year, occasionally feeling pains in the shoulder and back, but seldom having been off work even for a single day. During the whole of this time the pulsating prominence remained in a stationary condition as regards size, his general health was very good, and he looked so well that he does not think that any one suspected that there was anything the matter with him. His hours of work were from 6 A.M. to 6 P.M. During the greater part of that period (twelve hours) he was on his feet, standing or walking about superintending the work in the manufactory; he used to go many times a day from the top to the bottom of the building, generally using the hoists, but not unfrequently (certainly several times a day on the average) walking from the bottom to the top of the stairs.

During the whole of period (seven years) he had no special treatment. Throughout life he has been a remarkably steady, regular-living man; he has never had rheumatism nor syphilis, and unless it were the accidents previously described he knew of no possible cause of the condition.

Some three months before this report was made, the pains in the chest, shoulder, and back became much worse, and the tumor at the same time increased in size.

Electrolysis was suggested, but he decided against the operation. It was therefore agreed to continue the iodide in full doses, to relieve the pain by subcutaneous injections of morphia, to keep the patient at absolute rest on his back in bed, and to apply a plaster as a support over the tumor externally.

The subsequent progress of the case was, as had been expected, short; the tumor continued to increase in size, and finally ruptured on March 12.

—At the Pennsylvania Hospital for the Insane in West Philadelphia, a cottage was formally opened June 16. This cottage is a step on the part of the hospital managers to establish a system of cottage treatment which will furnish patients who can afford it with more home-like surroundings, and group them into families. The cottage is attractive in its architecture and comfortable in its furnishing. It will accommodate about sixteen persons.

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TREATMENT OF CANCER OF THE LARYNX.

The recent death of the Emperor of Germany will attract attention anew to the important subject of the treatment of cancer of the larynx, which has been so much discussed during the year just past. The great question is: Shall cancer of the larynx be treated by a surgical operation or not? and, if by surgical operation, what one offers the best chance of success?

In studying this subject no one can overlook the fact that each case is likely to present peculiarities which must influence a decision, and prevent this from following strictly the general rules which can be deduced from a study of statistics. Still, these general rules are of great value; and they are, in fact, indispensable to a wise determination in any particular case.

It is with great interest, therefore, that we examine a careful paper on the treatment of cancer of the larynx published by DR. MAX SCHREIER, of Berlin, in the *Deutsche med. Wochenschrift*, June 7, 1888. In this paper Schreier gives the result of an analysis of the features presented by one hundred and twenty-five cases subjected to various methods of treatment. He found in the whole number only four which were treated without operation. Of these patients one lived but two months, one twelve months, one fourteen months and one two years after coming under medical observation. In seventeen cases tracheotomy was performed. Of these patients, seven died within eight days and the rest within nine months. In nine cases laryngotomy was performed and the growth removed through the incision. Of these patients, three died within fourteen days; in three there was recurrence of the morbid growth within about a year. Three patients are said to have been cured; but in the case of only one can this result be properly claimed. Partial extirpation of the larynx was performed in thirty-three cases. Of these patients five died within six weeks. In four cases recurrence took place within three months and in one after sixteen months. Four patients remained free from recurrence for periods varying from one to three months, two from three to six months, one for seven months, and one for fourteen months. These are hardly to be reckoned as cures, as the time of observation is too short. But five of the patients operated on in this way had no recurrence for periods varying from nineteen months to seven years, and may be regarded as having been cured.

Total extirpation of the larynx was performed in sixty-eight cases—a little over half of all. Eighteen of these patients died within two weeks, and five within six weeks. Recurrence took place in seventeen cases—in twelve within six months, in three within nine months, and in two at a later period. Six of the patients died of intercurrent disease, and twenty-two are said to have been cured. However, thirteen must be deducted from this number, as having been too short a time under observation, leaving only nine who remained free from cancer for periods varying from sixteen months to three years and a half.

Removal of the morbid growth through the mouth was attempted in four of the cases studied by Schreier, and only one of the patients can be fairly regarded as having been cured.

These results seem to indicate that the choice in the treatment of cancer of the larynx lies between letting the growth alone and performing partial extirpation of the

larynx. Tracheotomy, laryngotomy and total extirpation of the larynx seem to be much more dangerous to the life of the patient and the latter two to offer less hope of preventing recurrence, while the former, of course, is at best only a palliative operation; while attempts at removal through the natural passages do not offer much hope of a cure As between a purely expectant method and partial removal of the larynx, the choice is not clearly pointed out by a study of statistics, and it must be determined by the condition of the patient, and the character and extent of the morbid growth.

These conclusions are, we believe, of great value; although, as we have said above, they must be regarded not as establishing fixed rules, exactly applicable to all cases, but rather as indicating general principles which ought to be taken into careful consideration by all surgeons. Experience in the treatment of cancer of the larynx may justify the choice in any case of a method which seems less favorable than some other, regarded in the light of statistics alone; but we believe it will be wise for most of our readers to follow the indications we have pointed out, and to choose between leaving the case to Nature or giving the patient the chance of relief or cure offered by a partial extirpation of the larynx.

INDICATIONS FOR VAGINAL AND INTRAUTERINE IRRIGATION AFTER LABOR.

It has been but a short time since it was customary in lying-in hospitals to use the vaginal, and even the intra-uterine douche, as a routine practice during the puerperium, as a prophylactic against septicæmia. This measure was almost universally commended by authorities, and its introduction even into private practice urged by many. The method was based upon the indefinite ideas concerning the nature of puerperal infection then prevalent. And in England, where great stress is laid upon the exanthemata as frequent causes of puerperal mischief, and the atmosphere is regarded as a common medium of contagion, and auto-infection is considered a fact, this practice is still recommended. With the growth and more general acceptance of the germ theory of puerperal sepsis, the methods of infection have been more closely studied, and it is now the accepted belief that when infection occurs it is almost always during labor, or immediately after, and that the poison is conveyed upon the fingers, instruments or utensils brought in contact with the genitalia—the atmosphere serving as a medium of contagion only under rare and exceptional conditions. Also, that the genital passages of the healthy parturient, at the beginning of labor, are not septic. Thus attention has been directed toward disinfecting everything coming in contact with the parturient canal, instead of waiting until the poison has gained entrance, and then using germicidal solutions, by irrigation, to destroy it. Garrigues, whose teaching and results have largely influenced hospital practice in this country, uses a single vaginal douche after normal labor. Where efficient antiseptic precautions have been employed during labor, this cannot be regarded as a measure of disinfection, but rather as one of extra precaution, defensible in hospitals, on the ground of the almost ever present danger of infection, and that when given by the physician himself it can be used with safety. It can also be defended by the practical argument that the results of the method have been most excellent. This is a very different matter from the routine use of vaginal injection, during the puerperium, by the nurse. There are good reasons for the belief that infection has not infrequently occurred from the introduction of decaying organic matter on imperfectly cleansed syringe nozzles, where this method has been employed. In private practice, when a normal labor has been properly conducted, neither a vaginal nor intra-uterine douche is indicated.

By irrigation we may expect to accomplish two things: remove foreign matter, and disinfect the utero-vaginal canal. Hence irrigation is indicated whenever material liable to undergo putrefaction, such as particles of secundines, clots, or detritus from a macerated fœtus, is present or retained; and when infection is known to have occurred, or there

is reasonable ground to suspect it. It is a well-known clinical fact that tedious labor, and manual or instrumental delivery, favor puerperal sepsis. This is largely explained by the present views on the methods of infection. After such labors a single antiseptic irrigation is called for, since there is then reasonable ground for fearing infection. Where manipulations have been made within the cavity of the uterus, it, as well as the vagina, should be douched. So, also, where labor is complicated by a putrescent fœtus, or other matter, or by gonorrhœal vaginitis, irrigations should be used and continued.

Irrigation finds its best indication in the disinfection and removal of septic material from vagina and uterus. When a diagnosis of puerperal septicæmia is made, the douche should at once be used. Since infection takes place, in the majority of cases, through lesions of the vagina or vulva, only vaginal irrigation should be employed, unless the symptoms be urgent, or a relaxed uterus painful on pressure, points out the site of absorption. This irrigation is to be repeated at intervals of three or four hours. If the symptoms do not subside within six or eight hours, or if they grow worse, the uterus also should be washed out. Opportunity is afforded to examine the entire tract during the manipulations. After thoroughly douching the vagina, the aseptic finger should explore the vagina and cervix, and, assisted by the other hand manipulating through the hypogastrium, the uterine cavity, as far as possible. A patulous os, retained clots or fragments of secundines, a necrotic odor clinging to the examining finger, and tenderness or swelling of the uterine tissues are the most characteristic signs of involvement of the uterus. It should not be forgotten that a foul odor is by no means necessarily present in puerperal septicæmia, but that, on the contrary, it is frequently entirely absent. When such an odor is present it is usually due to putrefaction of the contents of the vagina or uterus, which, with an intact mucous membrane, may be present without septic absorption or fever. When attached fragments of placenta are present, especially if large, the use of the douche should follow the removal of the mass by the finger or curette. Shortly after intra-uterine irrigation, and especially after emptying the uterus of decomposing material, a chill with rise of temperature not uncommonly occurs. This is usually of short duration, and in general the temperature and symptoms are markedly influenced for the better. Especially may this happy result be expected in cases of putrid infection, where the fever is due rather to the absorption of the products of decomposition, than to the action of the virus on the tissues proper. The intra-uterine douche, where it is necessary to repeat it, should seldom be used oftener than once or twice daily. The vagina, however, may be irrigated at intervals of three or four hours. Iodoform, when used within the uterus, will diminish the necessity for the frequent use of the douche. Obviously injections give the best results when resorted to early. In cases of putrid absorption the reservoir of supply is removed, and in those in which the tissues are primarily invaded, the supply of the contagium is limited. When once the germs are within the tissues, they are beyond the influence of irrigation. In the unfortunate, progressive cases, in which tissue invasion has been great, the effect of local treatment is slight, and it is sometimes actually harmful, instead of beneficial. There is a growing opinion that the douche is useless under these circumstances. Mundé, especially, records himself as opposed to its routine continuance. Wherever there is putrid material to be removed, or a fetid discharge to be overcome, injections are indicated. But when these ends have been met, if the patient does not improve, and especially if shock is produced, after a fair trial the douche should be abandoned, or only an occasional vaginal injection be given.

The instruments necessary for the vaginal douche are, preferably, a fountain syringe and a bed-pan. The patient should not be disturbed during its administration. The two precautions necessary for safety are, to have the syringe free from air, and to secure

a free outflow for the solution. For irrigating the uterus the modified Bozeman canula is perhaps the safest and best instrument, being attached to a fountain syringe. Unless an examination is to be made, and except where difficulty is met in introducing the canula, the woman should not be disturbed. After douching the vagina, one or two fingers are introduced into the cervix, and the instrument gently inserted. Where no special instrument is at hand, the common semi-flexible catheter, with some additional holes for the exit of the fluid, answers the purpose admirably. Here the return flow must be especially watched. The solution should be allowed to flow until it returns clear and odorless. From one to three pints is required. After the tube is removed from the uterus any flaky matter is washed from the vagina. Here also safety depends on the exclusion of air from the irrigator, and the total discharge of the solution. The uterus is emptied by securing contraction with frictions and compression, assisted by the use of ergot, the vagina by retracting the perineum. Where difficulties are encountered, or an examination is to be made, the patient should be placed cross-wise on the bed, in the ordinary lithotomy position. Gentleness is highly important. Vaginal irrigation may be entrusted to the nurse; but the uterus should be washed out by the physician only.

For general use a solution of corrosive sublimate—one part to two or four thousand—is preferred, as being a safe and yet an efficient germicide. Where kidney disease or marked anæmia is present, a weaker solution—one to ten thousand—may be used, or the usual solutions may be followed by the weaker, by carbolic acid solution, or by plain boiled water. Carbolic solution, in a strength of from two and a half to three per cent., is efficient, but has the disadvantage of its odor. The solutions should be used at a temperature of 110° F. to 115° F. Cases of sublimate poisoning are reported; but where ordinary precautions are used to secure the thorough evacuation of all fluid from the uterus and vagina, they are certainly not to be expected.

HIGHER MEDICAL EDUCATION.

In the Reporter, June 2, 1888, we called attention to the steps which we believe to be most urgently needed for the improvement of the standard of medical education in this country. It is with satisfaction that we call attention now to the fact that, at the last meeting of the Medical Society of the State of Pennsylvania, a discussion which took place disclosed the fact that a very large majority of the members of the Society hold precisely the views which we do. The mind of the Society seemed clear as to the necessity for a general adoption of a three years' course of study, and the establishment of State Examining Boards. An effort was made by one member of the Society to prevent endorsement of a resolution urging State legislation of this sort in Pennsylvania, on the ground that it involved a breach of the Code of Ethics. The Society, however, showed plainly that it had no such idea itself, and went straight at the important subject, without stopping long over this antiquated and wearisome objection.

So much is a proper cause of congratulation to the profession. Another matter for congratulation just now is the fact that the Jefferson Medical College has just announced that it stands with those schools which exact a three years' course; and that, after the beginning of the Winter Session for 1890, which is the earliest moment practicable, in view of implied contracts with students already entered, it will exact three years of study from those who wish to have its diploma. This action is the result of a movement from the Faculty of the college, and recognizes the fact that no student can learn, in a two years' course, the things now necessary for a fit practice of medicine.

In connection with this announcement we note the assertion that Harvard and the University of Pennsylvania are the only medical schools in the East which have heretofore required three years of study from their students. This statement overlooks the Woman's College in Philadelphia, which is a three-year college; and it is in diametric opposition to the claims of another institution

in Philadelphia, which states in its catalogue that its term is three years. We have before this heard it said that this claim is not true, and that there are ways in which men who have not been studying three years in any medical school can get a degree from it. We trust there is a mistake about this, and that all the regular medical schools in this city can be counted on as conscientiously devoted to the principle of three years of study. They are all openly committed to the principle, and openly advocate State examinations to decide the question of fitness for a license to practice. This, as we have said before, is an end for which all who desire the advancement of medical education in this county should strive, and it is a state of affairs which no really good medical school should fear.

PUBLIC DISINFECTION.

We learn from the *Bulletin Médical*, May 30, 1888, that the General Council of the Seine has decided to procure light movable ovens, intended for the disinfection of linen, clothing and hangings which have been used on or about persons affected with contagious diseases. The Prefect of Police has also sent out a circular to various officers of the city, notifying them that each canton of the Department of the Seine is provided with one of these apparatuses, and where it is to be found. One of these heating appliances is to be sent free of charge to any place named by a physician, to be used for disinfecting linen, mattresses, covers, curtains, carpets, and such things; and the public officers are instructed to inform the people of their neighborhood that the means of disinfection thus supplied—steam under pressure—is efficient and will not injure the fabrics subjected to it.

This excellent plan might well be adopted in other cities than Paris. In our own country, it would be a wise thing to provide similar means of disinfection, which could be taken to different houses when infectious diseases have occurred, and used without charge by those who need them. Nothing is more difficult sometimes than to carry out a thorough disinfection of the premises in which a contagious disease has run its course. For the poor, the expense is often a serious obstacle; and for the rich the means of disinfection are often almost impossible of attainment. There are very few cities—perhaps there are none—to which such a provision as has been made in Paris would not be a great boom; while, if it were the means of limiting the spread of contagious diseases, its value to the community would be inestimable.

We commend the example of Paris, in this respect, to the notice of our readers, and to our countrymen in general, adding the suggestion that such a service of portable disinfecting machines be joined to a well-ordered system of disinfecting houses. The two belong naturally together, and deserve to be put in practice in this country.

SUPRAPUBIC LITHOTOMY.

At the last Congress of the German Surgical Society, Dr. Neuber, of Kiel, proposed a method of performing suprapubic lithotomy, or cystotomy, in "two times," which he thinks will obviate the risks of peritonitis and phlegmonous infiltration of urine. His method consists in cutting down to the bladder, and attaching it by a few sutures to the edges of the abdominal incision. The wound is then tamponned, and kept open for five or six days. At the end of this time the bladder is cut into, and the purpose of the cystotomy is carried to completion. An attempt is now made to secure union of the wound by first intention, and, if this is not successful, it is treated by drainage and continuous baths.

This method is only a modification of one which is by no means recent; for it is said to have been put in practice at least once in 1773, by Le Blanc, and to have been proposed for regular employment in 1832, by Vidal de Cassis. After a few trials, however, it was entirely abandoned. It might be tried by any one who is too timid to perform suprapubic cystotomy in the usual way; but we agree with Von Bergmann and Trendelenburg, who think that the latter is generally as safe as that which Neuber proposes. The fact is that supra-

pubic cystotomy is not an operation essentially dangerous, and its chances are not materially improved by any attempt to secure union of the surrounding tissues before the bladder is opened.

NOT LIFE, BUT DEATH.

A number of the daily papers of this country have recently cited the following interesting story, taken from the Aroostock *Pioneer*, as furnishing an instance of the power of the mind in prolonging life: A young married man, who was married last fall, had pneumonia. His wife was in Minnesota, where he had intended to join her soon. A telegram was sent to her and she arrived in season only to see her husband alive. He seemingly fought against death to see her once more. As she entered the room he rose in bed and remarked, "I wanted to see you and am now willing to go." After these words were spoken he fell back upon the pillow, turned upon his side and expired.

It seems a pity to spoil such an interesting and romantic story; but the fact is that it illustrates, not the power of mind in prolonging life, but the peril of physical exertion when life is trembling in the balance. The poor fellow no doubt precipitated his death by rising in bed; and he might perhaps be living to-day, and have missed newspaper fame altogether, if he had kept on his back.

Book Reviews.

[Any book reviewed in these columns may be obtained upon receipt of price, from the office of the Reporter.]

A MANUAL OF THE OPERATIONS OF SURGERY, FOR THE USE OF SENIOR STUDENTS, HOUSE SURGEONS AND JUNIOR PRACTITIONERS. By Joseph Bell, M. D., F. R. C. S., Edin., Consulting Surgeon to the Royal Infirmary, etc. Sixth Edition, revised and enlarged. Small 8vo, pp. xvi, 336, with 4 plates. Edinburgh: Oliver & Boyd, 1888. Price, 6 shillings.

This is a handy volume which has met with much success in Scotland, and seems to deserve it. It is a very readable presentation of the operations taught at Edinburgh. It does not show much familiarity with the surgical work outside of Great Britain, and it may not be unfair to judge its general relation to it by the fact that it says "Dr. Bigelow, of Boston, has lately been highly commending a method which he has called litholapaxy"—which refers to an occurrence nine years ago, and by no means indicates the position of Prof. Bigelow or of his operation at the present day

ANNUAL OF THE UNIVERSAL MEDICAL SCIENCES. Edited by Charles E. Sajous, M. D., etc., and seventy associate editors, etc. 5 volumes, 8vo. Philadelphia and London: F. A. Davis, 1888.

These five handsome volumes are the results of a labor which cannot be appreciated by those who have not shared in it, and of a degree of enterprise on the part of the editor-in-chief and the publisher which is in the highest sense creditable to both. There is no work to compare with it in the English language, and only one or two in the world. It contains a selection of the points worth noting in the articles of value on medical subjects published during the year 1887, arranged and classified and subdivided, when the amount of matter permitted of it, into the subsections of a disease—etiology, pathology, treatment, etc. The associate editors have in most cases introduced their own views, and so the work is in reality more than a mere reference book, and compares very favorably with such publications as Schmidt's Jahrbücher, La Revue des Sciences Médicales.

This being the first year of issue, it is not remarkable to find a certain unevenness in the articles. Some of the editors have introduced too much of their own opinions, and some too little. Another defect, which we think of some consequence, is the brevity of the references, merely the name of the publication referred to being given, and no information as to date, volume, number or page. In this matter we think Virchow and Hirsch's Jahresbericht would furnish a suggestion for improvement.

As a whole, the work deserves much praise, and we can heartily commend it to the attention and patronage of our readers. It furnishes an excellent epitome of medical science for the year 1887 at a very reasonable price. We hope the work may continue and prosper!

Pamphlet Notices.

[Any Reader of the Reporter who desires a copy of a pamphlet noticed in these columns will doubtless secure it by addressing the author with a request *stating where the notice was seen* and enclosing a postage stamp.]

The Pulley Method of Advancing the Rectus, with Indications for its Employment. By A. E. Prince, Jacksonville, Ill. From the *Ophthalmic Review*, September, 1887, and the *St. Louis Med. and Surg. Journal*, March, 1888. 8pp.

An Aseptic Atmosphere. Club-Foot. A Rectal Obturator. Palatoplasty. By David Prince, M. D., Jacksonville, Ill. *Journal Press*, 1888. 30 pp.

—Dr. A. E. Prince's pamphlet contains an interesting and clear description of the method which he employs in the operation known as advancing the rectus. This consists essentially in placing a "pulley-suture" in the sclera, near the cornea, and looping through it another suture, which includes the capsule, muscle and conjunctiva. This method has given him excellent results, and he commends it to the notice of other operators. His pamphlet is illus-

trated with excellent wood-cuts, which add much to the value of the description of his method.

—This collection of reprints by Dr. David Prince is a little too comprehensive to permit of justice being done to it in the space at our disposal. The paper on an aseptic atmosphere has been noticed before; that on club-foot describes a method of operating and a shoe which shows great ingenuity. The rectal obturator described and figured does not seem to have been put to the test yet, and it is impossible to express any opinion as to its merits. The paper on palatoplasty describes a form of bead-suture and may be commended to the attention of those who operate for deformities of the soft palate.

CORRESPONDENCE.

A Hydrophobia Question.

EDITOR MEDICAL AND SURG. REPORTER:

Sir:—The following occurrence took place in this vicinity about fifteen years ago: Two young men, farmers' sons, belonging to two well-known families, both of whom were robust, healthy, and keen sportsmen, were upon the same day, at different hours, passing along the Ellisburg road, half a mile from this town, when they espied a dog lying along the fence—a dog strange to them, who were familiar with all the dogs in the neighborhood. With the instincts of sportsmen, each, unknown to the other, stopped, and stooped down to see what was the matter with it. Both were snapped at and bitten, the one on the finger; the other on the face. The wounds were so slight to these stout men that they paid no attention to the injury, and forgot it. In a few weeks (I made no memorandum at the time) they were taken sick within a few days of each other. They lived a mile apart. One was attended by the late Dr. Jennings, of this place, an old and experienced physician; the other by a homœopath. Dr. Jennings, who was familiar with tetanus, told me he had never seen a case of hydrophobia. When he paid his first visit he recognized a strange, and, to him, an unknown disease. On the next day the symptoms resembled what he had read of hydrophobia, and he asked his patient if he had been bitten by a dog. He said no, and it was only after much questioning that his patient could recall the above circumstance. In a few days the man died in great agony. The other man, attended by the homœopath, exhibited the same symptoms, told the same story, and promptly died. Neither ever knew that the other was sick. If the disease that attacked these two men was not hydrophobia, what was it? The dog disappeared without any other proof of its having rabies. Yours truly,

JOHN R. STEVENSON.

Haddonfield, N. J., June 8, 1888.

[Our correspondent asks a hard question, and we do not expect to be accused of timidity if we decline, at this distance, and after a lapse of fifteen years, to make a diagnosis in regard to cases of which we have so brief and incomplete an account. Considerable experience in meeting queries like this has demonstrated the fact that it is not wise to turn aside from a systematic study of any disorder to answer individual objections founded upon isolated and more or less imperfect observations. We can assure our correspondent that stories far more credible on their face than the one he gives, have been found to be wholly incorrect. His may also be incorrect in some important detail; and it can no more settle the specific nature of so-called hydrophobia than any other of many which are hard to explain.

We publish his account of these cases, so that others may hear of them and give them what weight they deserve. But we have no idea that they are conclusive of anything, except the faith of the doctors and patients in hydrophobia.—Editor REPORTER.]

Spermatorrhœa and Pulvermacher's Belts.

EDITOR MED. AND SURG. REPORTER:

Sir:—I would like to know what your opinion is of Pulvermacher's belts for the cure of spermatorrhœa; and would you recommend it for this disease? Please answer through your journal, of which I am a reader, and oblige, Yours truly,

Philadelphia, MEDICAL STUDENT.
June 13, 1888.

[The only sensible course to pursue in spermatorrhœa is to consult a medical man in whom one has confidence, and to run no risks from any "quack" method of treatment.—ED. REPORTER.]

Quadruple Amputation; Correction.

EDITOR MED. AND SURG. REPORTER:

Sir:—I see a mistake has been made in the strength of the dressing solution in the report of quadruple amputation by me in the MEDICAL AND SURGICAL REPORTER, May 26, 1888. It should read: "After operating I used hydr. chl. cor. ℥iv, sp. vini rect. f℥iv; one teaspoonful of the mixture to one pint of tepid water. It now reads, hyd. chl. cor. ℥iv, sp. vini rect. ℥iv. This is entirely too strong. Please correct.

Yours truly, G. C. WALLACE, M.D.
Rock Rapids, Iowa,
June 11, 1888.

Notes and Comments.

A Madstone in Chicago.

The New York *World*, of June 10, says that a State Street bookseller has a madstone which is reported to have made some marvellous cures of threatened hydrophobia lately. The fifth case within thirty days was a little boy who was bitten by a pug dog a few days before. The stone was applied two days later, and adhered until the next morning. The worst case of the five was that of a little girl, who was bitten by a dog five days before the stone was applied. The attending physician said erysipelas had set in; the hand had turned black and was swollen out of shape; she was very feverish and had become sick. The stone adhered four days, when the patient was apparently perfectly well In every case, it is alleged, a perfect cure has followed the use of the stone.

This is what they tell about Chicago.

Sam Jones on "Faith Cure" and "Christian Science."

"I'll tell you where this faith cure comes in. There's an old brother and a sister who have been taking all the nasty, quack patent medicines on the market for the last ten years. Somebody comes along and prays over 'em, and they quit using the patent medicines, and they are well again. They say it was faith that cured. It was faith. It was faith which caused them to quit taking old patent nostrums, which cured them."

"I don't say I belong to the Christian Science crowd, or anything of that sort; but I thank God, that by the side of my sick wife I may kneel down and pray that the remedies given by the physician may prove effective. I don't pray over the supernatural. I pray over the pill.

A "Christian Scientist" Gets Off.

The Grand Jury for Middlesex County, Mass., in its report June 10, found no bill against Mrs. Abbie H. Corner, the Christian Scientist of West Medford, charged with manslaughter in causing the death of her daughter, Mrs. Lottie A. James, by neglecting to provide proper medical assistance at the time of her confinement on March 18.

Authority of Boards of Health.

At the meeting of the Board of Health of Philadelphia, June 13, an opinion of the Attorney General was read, which states that acts of Assembly which he quotes "clearly embrace and imply the power in the Board of Health of a city of the first class, and the proper health officer under their direction, to remove a person infected with small-pox to the hospital without his consent, or, if a minor, the consent of his parents and guardians." He further states: "If vaccination is a precaution reasonably necessary to limit the spread of contagion in the public schools, and the presence of an unvaccinated pupil endangers the general safety, or is a condition likely to directly result in the propagation and spread of disease among pupils generally, then it would be proper, by regulation, during the time of the prevalence of such disease, or in view of its threatened approach, to exclude such pupil from contact with the other attendants upon the school." There is a very big "*if*" in this opinion!

Remedy for Catarrhal Affections of the Respiratory Tract.

The *International Medical and Surgical Synopsis*, May, 1888, says: Through our friend, Dr. Phillip Scholz, we learned of a combination of remedies used some years ago by an old French physician of this city, in all catarrhal affections of the respiratory tract. We have had occasion to use it in the large clinic attached to the college, in the cases named, and for the mitigation of the cough of phthisis. The mixture is as follows:

℞ Terebene .....f℥viiss
Coniine.....℥ss
M. S.—Four drops to be administered to an adult every four hours.

The same compound is to be used by inhalation, twenty to thirty drops being mixed with a cupful of hot water, and the vapor inhaled through a funnel, two or three times a day.

In a number of cases of phthisis pulmonalis, in which all the known remedies to allay cough were tried to no avail, the combination acted admirably.

Hydrofluoric Acid in Digestion.

Most of the authors who have employed hydrofluoric acid in the treatment of phthisis have been struck with the fact that the patients who use it show decided increase of appetite. Lépine suggests that this action is the result of a direct influence of the acid upon the mucous membrane of the stomach. In order to test this he gave the drug to chlorotic patients and found that it answered as well as hydrochloric acid.—*Bulletin Médical*, April 15, 1888.

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Medical and surgical reporter
(Philadelphia)

GERSTS